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HEALTH CARE NEWS

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The Pulse

States Vary Widely in Vaccination Success

By Kelsey Hackem

The rollout of COVID-19 vaccinations in the United States has picked up momentum after a slower-than-expected start at the beginning of the year.

By January 22, 39.9 million vaccines had been distributed, according to the U.S. Centers for Disease Control and Prevention (CDC), and 19.1 million were administered. Of those administered, 2.3 million vaccines were given to residents in long-term care facilities through the federal government's distribution program.

As of January 21, West Virginia had administered the highest percentage of vaccines, at 72 percent, followed by North Dakota (71 percent) and South Dakota

VACCINATION, p. 4

Hospitals Lose Fight to Protect Price Secrets

By Joe Barnett

After multiple court challenges, hospitals must now publicize the cash prices for 300 "shoppable" services and, starting next year, the discounts they negotiate with insurers.

The hospital transparency rule was opposed by the American Hospital Association, U.S. Chamber of Commerce, and other groups as an alleged violation of the First Amendment rights of providers and insurers and for requiring disclosure of trade secrets. A federal district court dismissed the AHA lawsuit seeking to overturn the rule on June 23, 2020. The U.S. Circuit Court of Appeals for the District of Columbia unanimously denied an appeal of the district court's decision by AHA, on December 29.

PRICE SECRETS, p. 6

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Congress Ignores Doctor Shortage, in COVID Relief Bills

By Bonner Cohen

Congress bypassed an opportunity in recently enacted COVID-19 relief bills to significantly increase the number of Medicare-funded residency positions at hospitals.

In the last package, which amounted to $1.4 trillion in government spending and was signed by President Donald Trump on December 31, lawmakers set aside $120 million for 1,000 new physician training slots over the next five years. A more ambitious bill on the table would have added 15,000 residencies over the next five years. It failed to make it into the year-end coronavirus relief package.

"The increase of 1,000 slots is a good first step but a far cry from what is needed," said David Balat, director of the Right on Health initiative at the Texas Public Policy Foundation.

PHOTO COURTESY GAGE SKIDMORE/FLICKR

Pandemic Amplifies Problem

It has taken a global pandemic, the likes of which have not been seen since the Spanish Flu at the end of World War I, to expose a life-threatening vulnerability of the U.S. health care system: an acute shortage of medical personnel, especially emergency-room physicians.

With many hospitals around the country overwhelmed by the recent surge in COVID-19 patients, medical school graduates are having trouble finding residencies at a time when medical care is urgently needed. The governments' and public's reaction to COVID-19 has also decreased the number of opportunities for physicians after residency. A survey by the American College of Emergency Physicians found 20 percent of emergency medicine group practices laid off doctors last year, almost one-third furloughed them, and more than half cut hours or wages. As a result, many doctors who have completed their residencies are finding it difficult to secure full-time positions in a tightened job market.

Because people with non-COVID-19-related ailments avoided emergency rooms for fear of contracting COVID-19, cash-strapped emergency centers suffered a drop in admissions and revenues, and many ceased recruiting new doctors. The hardest-hit are the newly minted physicians, many of them heavily in debt from medical school.

Congress Controls Doctor Supply

Today's shortages are part of the long-lasting effects of congressional decisions dating back to the mid-1990s.

Guided by economists and physician groups who sounded the alarm that an impending physician glut would lead to needless treatments and higher spending, Congress, in the Balanced Budget Act of 1997, capped Medicare-funded residency positions at 1996 levels and paid hospitals to eliminate positions. As noted by the *Wall Street Journal* on January 4, Medicare has funded the vast majority of residency positions at hospitals since 1965.

The overabundance of physicians that was forecast a quarter of a century ago never materialized. Instead, the country now faces a shortage of doctors, brought on by an aging population and medical workforce and the federal government's limitation on the certification of new doctors. A third of the roughly 906,000 practicing physicians in the United States are over the age of 60, and the Association of American Medical Colleges (AAMC) forecasts a physician shortage of 54,100 to 139,000 by 2033. Shortages will be especially acute in geriatrics, primary care, and emergency care, the AAMC states.

With residencies having been capped at about 100,000 for more than two decades, the shortfall in physicians projected by AAMC was predictable. A 2019 report by AAMC found 44 percent of medical schools have moderate to major concerns about their inability to place graduates in residency programs.

Bypassing Congress

To attract qualified medical personnel to deal with the pandemic, some states have suspended state licensing requirements, allowing practitioners with a license from any state to provide care to their residents.

State licensing boards could also remove regulatory barriers obstructing qualified foreign physicians from practicing in the United States. States' rules fail to consider credentials from abroad, says Jeff Singer, M.D., a surgeon and senior fellow at the Cato Institute (see related article, page 18).

State licensing boards "require international medical school graduates who have completed post-graduate medical school training and are licensed to practice in other countries to repeat their entire graduate training in an accredited U.S. institution before receiving a state medical license," Singer wrote in the *Detroit News* on July 15.

"The blame lies with Congress and the states," said Paul Larkin, a senior legal research fellow at The Heritage Foundation's Institute for Constitutional Government. "As for the states, they should provide financial incentives for doctors to remain in the state where they have completed their residency."

Balat says the federal government's residency cap is unjustifiable.

"The shortage of physicians is due to congressional inaction to increase the residency caps," Balat said.

The United States needs more than 1,000 additional residency slots, Balat says.

"Lack of success in the residency application process, which is a reality for thousands of applicants every year, is what results in unmatched medical graduates," Balat said. "This is an incredible waste of knowledge and talent while we lament too few practicing physicians."

Bonner R. Cohen, Ph.D., (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

States Vary Widely in Vaccination Success

Continued from page 1

(65 percent), according to an analysis by *Becker's Hospital Review*. At the bottom of the list were California (37 percent), Virginia (36 percent), and Alabama (33 percent).

West Virginia was able to ramp up vaccinations after choosing to opt out of the federal partnership program run by drug store chains CVS and Walgreens and instead use local pharmacies, *The Conversation* reported on January 14.

An analysis on January 12 by the Committee to Unleash Prosperity found Florida led the nation in vaccinating seniors. Fifty-four percent of all administered COVID-19 vaccines in the satte went to people 65 years and older. The CDC does not break down rates by age in the national data set.

Slow Start

The Trump administration's Operation Warp Speed task force had set a goal of 20 million inoculations by the end of 2020. By the end of the first week of 2021, fewer than 6.3 million had been administered.

U.S. Health and Human Services Secretary Alex Azar told reporters on January 6 the holidays were to blame, along with the complexities of the distribution chain.

"There's always going to be a lag between available doses, then the ordering by the providers, then the shipping, then the actual administering of the vaccine, and then importantly, the reporting of those vaccinations," Azar said.

Of the federal agencies involved in the process, Azar stated, "the data aggregation system there is not yet perfect or real-time. There are entities not reporting."

Vaccines were being doled out by hospitals and other health care institutions, but pharmacy chains and health clinics have been working to join the list.

The vaccine requires a second dose within several weeks, and some analysts are suggesting lengthening the time period for the second dose until more people have received the first dose.

First in Line

Questions about priorities and speed surfaced once vaccinations began on December 14. Before leaving office, U.S. Rep. Tulsi Gabbard (D-HI) voiced her concern that essential workers were being placed in line before seniors and the elderly, who are at the most risk of serious illness from a COVID-19 infection.

"The mortality rate of our seniors is far higher than it is for anyone in any other age bracket," Gabbard stated in a video she posted on Twitter on January 2. "Our seniors need to be protected now."

The CDC's Advisory Committee on Immunization Practices (ACIP) issued recommendations for the order in which COVID-19 vaccinations should be offered. Phase 1a includes health care personnel and long-term care facility residents, and phase 1b includes persons over the age of 75 and non-health-care frontline workers. Individuals aged 65-74 are recommended in phase 1c.

Reasonable people can disagree over who should be prioritized for the vaccine, says Jeffrey Singer, M.D., a surgeon and senior fellow with the Cato Institute.

"There are some respected epidemiologists who believe the young and active—those most likely to spread the virus to others—should receive priority over nursing home patients who are relatively sequestered in their normal lifestyle," Singer said. "Most, however, believe that if the primary goal is to 'flatten the curve' so that hospital systems don't get overwhelmed, then the priority should be given to those who are most likely to need hospitalization."

Singer says there is consensus among epidemiologists that health care workers should be a top priority.

"All agree that frontline health workers are most at risk of catching and spreading the virus, both within health institutions and by bringing it home to their households," Singer said.

Government Obstacles

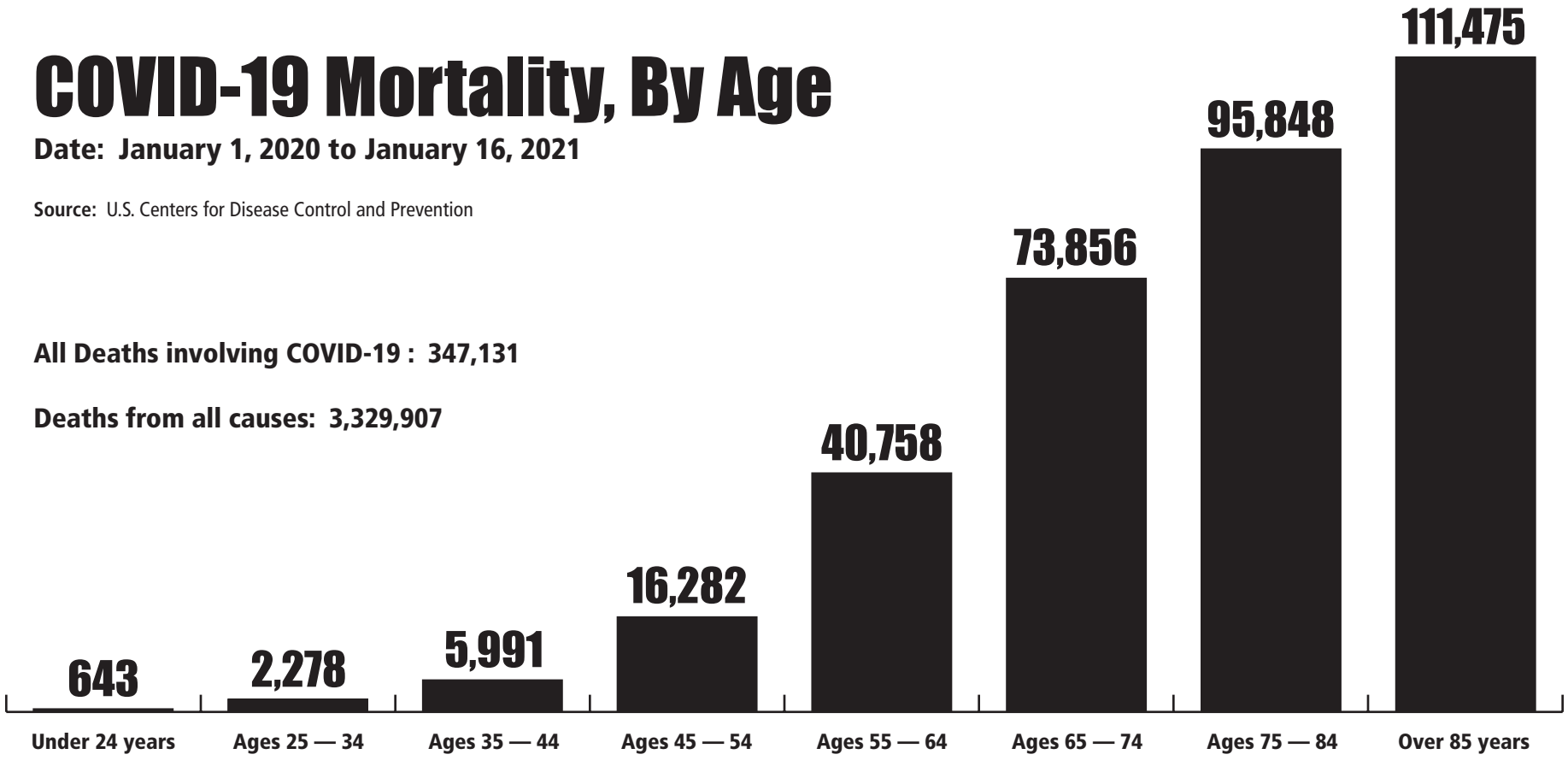
In any case, government micromanaging will make the problem worse, not better, Singer says.

"The problem is that when central planning—as opposed to markets—is the means employed to distribute goods or services to those people to whom they are most valuable, it is very difficult to get it right," Singer said.

The states must follow ACIP guidelines but are free to institute their own methods of distribution.

"Fortunately, with our federalist system, we have 51 different central plans, and in some states, they devolve central planning to even-more-local governmental agencies," Singer said. "So when errors are made, at least fewer people get harmed than would be the case if there was a one-size-fits-all central plan administered in Washington, D.C. And the decentralized approach also allows local governments to learn from one another about strategies that work and those that don't."

Kelsey Hackem, J.D. (**khackem@gmail.com**) *writes from the state of Washington.*



Health Care Workers Resist COVID-19 Vaccines

By Kelsey Hackem

Health care workers across the country are choosing not to receive the COVID-19 vaccine, for reasons ranging from political perception to concerns about potential side effects.

In Ohio, Gov. Mike DeWine reported 60 percent of nursing home workers declined the vaccine. In Los Angeles County, California, public health officials reported roughly 20 percent to 40 percent of frontline workers refused the vaccine. Similar stories are being reported from other states, including Texas and Virginia. The Associated Press reported on January 8, 2021 that in some health care settings up to 80 percent of the staff are declining to receive the vaccine.

Health care workers are considered a priority group for COVID-19 vaccines because government leaders see them as role models for vaccine compliance (see related story, page 5). A Kaiser Family Foundation poll found about 27 percent of the public remains vaccine-hesitant, reporting they probably or definitely would not get a COVID-19 vaccine even if it were available for free and deemed safe by scientists. The same survey found 29 percent of those working in a health care delivery setting were vaccine-hesitant.

"Despite preclinical trials that have suggested that the Moderna and Pfizer COVID vaccines are both safe and effective, there has been significant hesitation by many within the health care community to get these vaccines, with as many as 50 percent of frontline workers choosing not to get them."

CHAD SAVAGE, M.D.
PHYSICIAN, FOUNDER, YOURCHOICE DIRECT CARE

Doubts About Politics

Politics could be influencing the perception of the COVID-19 vaccine, says Chad Savage, M.D., physician, founder of YourChoice Direct Care, and policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"Despite preclinical trials that have suggested that the Moderna and Pfizer COVID vaccines are both safe and effective, there has been significant hesitation by many within the health care community to get these vaccines, with as many as 50 percent of frontline workers choosing not to get them," Savage said. "This has likely been greatly exacerbated by politicians such as Gov. Andrew Cuomo [of New York] who cast doubt on the vaccines for apparent political gain."

Cuomo made numerous public comments casting suspicion on the vaccine rollout, including an effort to speak with governors across the nation about fixing or stopping the rollout under President Donald Trump.

Need to Weigh Risks

Individuals should consider the consequences of contracting COVID-19 before deciding whether to reject a vaccination, says Savage, especially for older individuals and those with preexisting conditions.

"Though there remains significant variation in comfort level regarding the COVID vaccine, there should be much less hesitation among the elderly regarding getting the vaccine, as they are at dramatically higher risk from the virus," Savage said.

You should get the vaccine only in a place that is properly staffed and equipped to treat you, says Jane Orient, M.D., executive director of the Association for American Physicians and Surgeons and a policy advisor to The Heartland Institute.

"Shots are being given in drive-thru 'pods,'" Orient said. "You are advised to wait for a time in the parking lot before driving away. Medical personnel will be on the scene."

Potential Side Effects

On January 6, 2021, the U.S. Centers for Disease Control and Prevention (CDC) safety data showed that 11.1 out of one million administered COVID-19 vaccine doses caused an adverse anaphylaxis side effect. For comparison, the influenza vaccine results in 1.3 anaphylaxis responses per one million doses administered. There was no information released about other side effects, such as a fever requiring hospitalization.

Many people experience fever, fatigue, headache, and achiness after the second shot, which employers might want to consider when scheduling vaccines for employees so not everyone calls in sick at the same time, Orient says.

Temporary Bell's Palsy has been reported among some vaccine recipients, and vaccines are not recommended for pregnant women or those planning to become pregnant, Orient says.

There is also something called antibody-dependent enhancement (ADE) that could occur in persons who get infected after vaccination, Orient says.

"This has been reported with dengue, respiratory syncytial virus (RSV), and related coronaviruses such as SARS-CoV-1," Orient said. "Getting vaccinated may keep you from getting mild or severe symptoms if you get infected with SARS-CoV-2 (the cause of COVID-19) but may not prevent transmission to others. And rare individuals might get sicker due to ADE. Hence, you need to continue infection-control measures."

Individuals can request "fact sheets" that come with the vaccines, and the CDC offers a smartphone app for individuals to report side effects and get reminders for a second dose. AAPS also offers information on home-based COVID treatment.

Kelsey Hackem, J.D. (**khackem@gmail.com**) *writes from the state of Washington.*

Hospitals Lose Fight to Protect Price Secrets

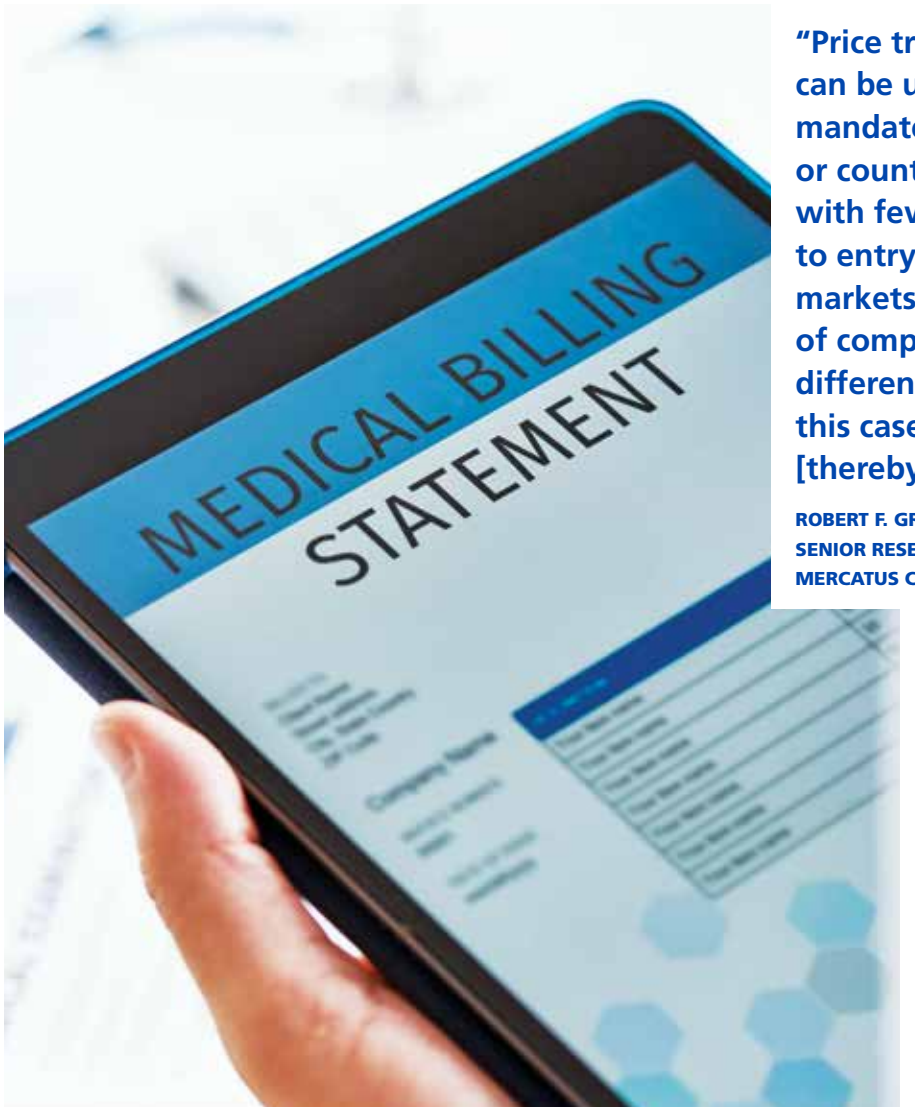
Continued from Page 1

The rule, implemented by the Trump administration, goes beyond the so-called "chargemasters" hospitals use that bear little resemblance to what patients or insurance companies actually pay for a procedure. Hospitals must now post the out-of-pocket cash prices they charge people without insurance, such as Canadians who come to the United States for faster health care than they can get north of the border.

There is support for price transparency across the political spectrum.

"Price transparency is included in the Biden-Sanders Unity Task Force Recommendations," said Cynthia A. Fisher, founder and chairman of PatientRightsAdvocate.org.

Price transparency is also a feature of *Health Care Choices 2020: A Vision for the Future*, published by the Health Policy Consensus Group, a task force of free-market economists, policy analysts, and think tanks, on October 20.



"Price transparency in health care can be useful, but transparency mandates will often be ineffective or counterproductive. In a market with few sellers and high barriers to entry—quite common in hospital markets—common knowledge of competitors' prices can induce different sellers, hospitals in this case, to constrict supply and [thereby] raise prices."

ROBERT F. GRABOYES
SENIOR RESEARCH FELLOW
MERCATUS CENTER

Trump Transparency Initiative

Hospitals and ambulatory care centers must now post prices for services that can be scheduled in advance, such as diagnostic procedures and elective surgeries. Additionally, health care facilities must post prices for 230 of the providers' most common procedures and 70 procedures specified by the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

The Price Transparency Requirements for Hospitals to Make Standard Charges Public, published in the *Federal Register* on November 27, 2019, was part of a health care initiative aimed at encouraging competition, improving quality, and reducing costs under an Executive Order issued by President Donald Trump on June 24, 2019. For each service, the hospital must list the average price and the price charged to cash-paying patients.

Beginning January 1, 2022, a related rule will require hospitals to disclose the discounted minimum and maximum prices they have negotiated with health plans and insurers for shoppable services.

Winners: Privately Insured

Whereas the reimbursement rates providers are paid by Medicare are transparent, privately insured patients haven't had a way to compare hospitals' prices, Fisher says.

"Individuals and employers are shopping blind, with little if any knowledge of prices or the significant price variation across hospitals and providers," Fisher said.

Consumers with employer-sponsored insurance will reap the biggest benefit, Fisher says.

"According to the RAND Corporation's recent survey, employer plans pay 2.5 times higher hospital prices than Medicare," Fisher said. "Former National Economic Council member Brian Blase explains how abundant price information will help employers shop for and design health benefits. The subsequent savings will enable them to pay higher wages and increase the number of workers they employ. Patients will now be in charge of their own health care decisions and savings."

Surprise Bill Solution

The rule will also reduce the problem of "surprise billing" of patients by out-of-network specialists such as anesthesiologists, Fisher says.

"Upfront price transparency will address the problem of surprise billing in nonemergency situations—90 percent of health care spending is nonemergent—as consumers will find price information much more easily," Fisher said. "Congress also recently passed legislation prohibiting providers from balance-billing patients in in-network facilities and in emergency situations."

Patients with high-deductible health insurance plans and Health Savings Accounts (HSA) will also benefit from provider price transparency, Fisher says.

"More than half of such customers do not reach their annual deductible, and thus face the full cost of health care services," Fisher said. "There is nothing [in the rule] that precludes HSA holders or cash-paying customers from obtaining further discounts if they're able to negotiate them."

Caveat: Limited Competition

The transparency requirements may not achieve their supporters' goals, says Robert F. Graboyes, a senior research fellow with the Mercatus Center at George Mason University.

"Price transparency in health care can be useful, but transparency mandates will often be ineffective or counterproductive," Graboyes said.

Price transparency in markets with limited competition can lead to tacit collusion, Graboyes says.

"In a market with few sellers and high barriers to entry—quite common in hospital markets—common knowledge of competitors' prices can induce different sellers, hospitals in this case, to constrict supply and [thereby] raise prices," Graboyes said.

Still, a lack of transparent pricing is also less than ideal, Graboyes says.

"None of this means that today's price opaqueness is good or necessary," Graboyes said. "While I don't claim that all mandatory price transparency is problematic, I'm not optimistic that these particular rules will bring prices down, and I have some concern that they will do the opposite."

Biden Unlikely to Repeal

The Biden administration will probably let the rule stand, Fisher says.

"We believe a repeal is unlikely: 90 percent of Americans support price transparency—[in] three separate surveys—as most Americans feel they should know prices before they receive health care services, as in every other industry," Fisher said.

"We are encouraging CMS and the incoming administration to stand strong, enforce the requirements, and ensure that hospitals are in compliance, allowing health care consumers to benefit from competition and choice through transparency in health care," Fisher said.

Joe Barnett **(joepaulbarnett@att.net)** *writes from Arlington, Texas.*

Trump Administration Clips the Wings of Cost-Driving Stark Laws

By Kelsey Hackem

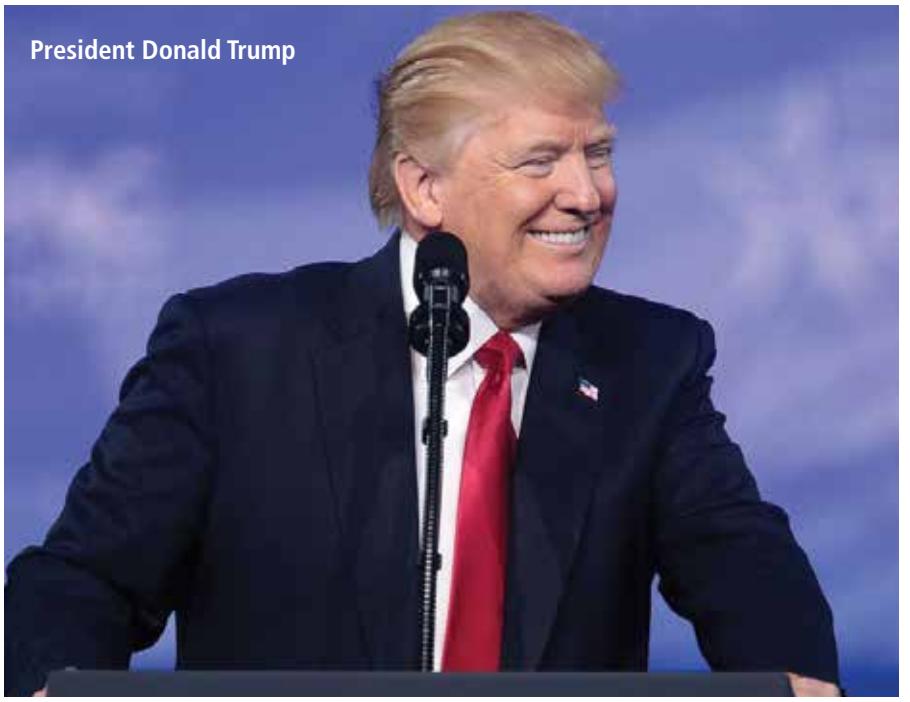
Physicians are now able to deliver more efficient care through Medicare thanks to new federal rules finalized by the Trump administration removing restrictions on patient referrals.

The rules roll back regulations under the Physician Self-Referral Law or "Stark laws," enacted in 1989. Rep. Pete Stark (D-CA) said he intended the laws to promote more ethical practices in making patient referrals. Stark laws and related anti-kickback measures were designed to prevent physicians from profiting from referrals to entities in which they had a financial interest.

Such laws were meant for a health care system that reimbursed providers on a fee-for-service basis, which created a perverse incentive to order more health care services. Today, the industry is moving toward "value-based" care, which rewards doctors for keeping patients healthy and out of the hospital.

Providers have argued for years that these laws and rules prevent them from coordinating patient care and forming outside relationships in fear of harsh liability fines under Stark laws or criminal sanctions from anti-kickback rules. For example, anti-kickback measures keep Medicare and Medicaid physicians from waiving co-pays. Another workaround involves hospitals hiring more expensive physicians through temporary placement agencies to avoid the liability from running afoul of Stark laws.

The new rules will amend the regulations to allow permanent exceptions for value-based arrangements, provide additional guidance on key requirements of the exceptions to the physician self-referral law, and reduce administrative burdens that drive up costs.



President Donald Trump

PHOTO COURTESY GAGE SKIDMORE/FLICKR

"Notice that there is no intent requirement to a Stark law violation. These kinds of mistakes are million-dollar mistakes. If you audit any hospital's books, you are likely to find something. If you audit a DPC practice's books you are likely to find that Medicare was never billed at all and that care is actually simple and affordable."

PHILIP ESKEW, D.O., J.D.
FOUNDER
DPC FRONTIER

Financial Burden to All

Complaints about Stark laws' burdensome regulations have become commonplace in the health care industry. Hospitals and hospital systems have complained the regulations force them to spend millions of dollars and a significant amount of time complying with the rules, which impedes patient care, directs money toward compliance with regulations instead of patient care, and drives up the overall cost of health care.

One red flag of violating the regulations is when a hospital pays a physician more than what is deemed "fair market value."

"I would argue that, in general, we have no idea what the fair market value is in much of health care," said Philip Eskew, D.O., J.D., founder of DPC Frontier and a policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

Eskew says "fair market value" is often determined by an influential group, not the free market. In this case, the American Medical Association (AMA), a private professional organization, determines how much Medicare should pay physicians and then owns and licenses those particular payment codes.

"The AMA then gets a cut of each transaction, similar to a credit card company," Eskew said. "This is the AMA's main source of income. Less than 10 percent of physicians are active dues-paying members of the AMA. Members of the AMA's RVS [relative value scale] Update Committee then decide what each code should pay, and Medicare and Medicaid argue they should pay less than various insurance companies."

Distorting the Market

The process does a poor job of reflecting fair market value or a patient's need for a procedure because it reflects only the negotiating and lobbying efforts of specialty physician and administrative groups that dominate the AMA's RVS Update Committee, Eskew says.

"They undervalue primary care while overvaluing specialty care," Eskew said. "This undervaluing of primary care has resulted in too many specialists and too few primary care physicians because primary care physician salaries reflect lower CPT code reimbursement amounts established by the AMA's RVS Update Committee."

Additionally, the ambiguities in the Stark laws made providers fearful of unintentionally violating the laws, which can lead to costly consequences. One problem that leads to these large fines is the fact that the government doesn't have to prove intent.

"Notice that there is no intent requirement to a Stark law violation," Eskew said. "These kinds of mistakes are million-dollar mistakes. If you audit any hospital's books, you are likely to find something. If you audit a DPC practice's books you are likely to find that Medicare was never billed at all and that care is actually simple and affordable."

An Industry of Whistleblowers

Although preventing health care fraud is important, the incentives created by Stark laws and other anti-kickback statutes provide an easy path to a million-dollar payday for hospital employees who catch their employers running afoul of regulations even if the mistake is unintentional, Eskew says.

The money adds up when an employee catches a mistake committed multiple times.

"As the original Qui Tam relator [the legal term for whistleblower], you would get anywhere between 5 to 15 percent of the total take hauled in by the government," said Eskew. "Some of these suits have been settled for over half a billion dollars by hospital systems. The largest was with Glaxo, at around $3 billion."

In a case settled in 2019, Sutter Health paid more than $46 million to settle Stark law violations, and the whistleblower who brought the claim received nearly $5.9 million of the federal government's recovery.

"When we kicked off our Patients Over Paperwork initiative in 2017, we heard repeatedly from frontline providers that our outdated Stark regulations saddled them with costly administrative burden and hindered value-based arrangements," said Centers for Medicare and Medicaid Services Administrator Seema Verma in a news release. "Ambiguities in the Stark law have frozen many providers in place, fearful that even beneficial arrangements might violate the law, which can come with dire and costly consequences. This has resulted in health care providers spending millions of dollars complying with arcane regulations instead of putting those dollars toward patient care."

Kelsey Hackem, J.D. (**khackem@gmail.com**) *writes from Washington State.*

Vaccines May Not End the Lockdowns

By Kelsey Hackem and AnneMarie Schieber

Public health officials are warning that lockdowns and other social distancing measures will remain in place after the COVID-19 rollout, throwing cold water on any optimism that the vaccine will bring a return to normal.

Timothy Brewer, M.D., a professor of medicine at the David Geffen School of Medicine at UCLA, said many restrictions will remain in place and it will take a long time for the vaccine to have pronounced effects.

"Given how long it will take to address those most in need, we will see no noticeable change for the near future, just because there isn't enough vaccine to have any meaningful impact immediately," Brewer stated in an article in *Healthline* on December 15.

A similar warning was given in the United Kingdom.

The U.K.'s top doctor, Jonathan Van-Tam, said at a news conference on December 31 it would be at least several months after the vaccines are rolled out before people should feel comfortable behaving with "wild abandon." Van-Tam told reporters it is not clear that vaccines will stop people from transmitting the virus even though they themselves may be protected, *The Times* reports.

"The mRNA vaccine directs human cells to produce the spike protein temporarily, and then the immune system responds to it within and outside of cells. While the CDC calls the spike protein 'harmless,' research has shown it is not only responsible for viral entry, but it may be responsible for many of the symptoms of COVID-19. Thus, the illness caused by the vaccine especially on the booster injection is explained."

PETER MCCULLOUGH, M.D.
INTERNIST, CARDIOLOGIST, AND RESEARCHER
BAYLOR HEART AND VASCULAR INSTITUTE

Public Losing Patience

Lockdowns have been in effect throughout the world for almost a year, and there are signs the public is losing patience.

In a study by the University of Southern California published on November 16, less than half of those surveyed reported full compliance with stay-at-home orders. Responses depended on age, with older people reporting they were more likely to engage in masking and other public health orders.

An anti-lockdown movement seems to be growing, says Jeffrey A. Tucker, editorial director for the American Institute for Economic Research and author of *Liberty or Lockdown*. Tucker told *The Heartland Daily Podcast* part of the reason for the reaction is that the lockdown policies have done a large amount of damage.

"It has been interesting to see how so many people have come around now to see that it has been such a gigantic mistake," Tucker said.

Vaccine Hesitation

There are signs the public is not robustly embracing the COVID-19 vaccines. A report in VOX on January 11 states at least 40 percent of U.S. health care workers have turned down an opportunity to receive the vaccine. Leftover vaccines are being distributed to those lower on priority lists, such as law enforcement officers and employees at public venues.

The response seems to contradict what studies in December reported. The Kaiser Family Foundation found health care workers were no different from the rest of the population in being hesitant about the vaccines. Less than 30 percent in both groups said they were unlikely to get the vaccine immediately. Eighty-five percent of health care workers in a survey by Yale Medicine and Yale-New Haven Health Systems said they were extremely likely to get the COVID-19 vaccine, but so far 53 percent have received one.

That trend has some officials worried.

"We want [health care workers] not only to protect themselves, but we also want them to be educating their patients so that everyone across the United States understands that these vaccines are available, that they have a good safety profile, that they are working," Nancy Messonnier of the U.S. Centers for Disease Control and Prevention (CDC) told VOX.

Vaccines the Silver Bullet?

Whether vaccines will provide a complete shield against the virus is also in question.

The results of clinical trials by manufacturers Pfizer-BioNTech and Moderna suggest immunity created through their mRNA vaccines is incomplete, "meaning that not all infections were stopped and there was no reduction in the handful of serious cases requiring hospitalization," wrote Peter McCullough, M.D., an internist, cardiologist, and researcher at the Baylor Heart and Vascular Institute, in a blog post on December 30 in TrialSiteNews.

McCullough has been working to expand treatment of COVID-19 at its very early stages in outpatient settings, such as with the off-label use of existing drugs. These drugs have shown promise in stopping the virus from replicating but their use outside of clinical trials has been blocked by federal health agencies (see related article, page 13).

McCullough says vaccines might not be a silver bullet.

"Incomplete immunity is expected since these vaccines raise antibody and cellular responses only to the spike protein portion of the virus," McCullough writes. "The mRNA vaccine directs human cells to produce the spike protein temporarily, and then the immune system responds to it within and outside of cells. While the CDC calls the spike protein 'harmless,' research has shown it is not only responsible for viral entry, but it may be responsible for many of the symptoms of COVID-19. Thus, the illness caused by the vaccine especially on the booster injection is explained."

Promoting Natural Immunity

Natural immunity "appears to be far superior to vaccination," McCullough writes.

"Because the Pfizer-BioNTech and Moderna clinical trials were analyzed prematurely after two of the planned 24 months of observation, we simply cannot know at this time if the vaccination will provide durable protection," McCullough writes. "Already there is discussion of, once vaccinated, to make a commitment to annual or semiannual booster shots."

Natural immunity has been hampered by lockdowns and the abundance of health precautions pushed by the CDC, Tucker says.

"All the sterilizations people are doing, all the social distancing, staying indoors, masking: these things are weakening our immune systems," Tucker said. "Immune systems get better with practice and through exposure, and not by living in a perfectly sanitized world in isolation like some primitive tribe. It is dangerous to our health."

Kelsey Hackem, J.D. (**khackem@gmail.com**) *writes from the state of Washington. AnneMarie Schieber* (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

Lawmakers in Michigan Unable to Stop Lockdowns

By Jesse Hathaway

Michigan legislators are trying to gain control over the state's public health departments, which have jumped in to restrict activity after a set of state executive orders to curb COVID-19 were deemed unconstitutional.

Before the Michigan Legislature's session adjourned in December 2020, state Sen. Lana Theis (R-Brighton) introduced a bill that would have required the director of the Michigan Department of Health and Human Services to seek legislative approval for any emergency public health orders lasting longer than 28 days.

Senate Bill 1253 (S.B. 1253) would also have retroactively canceled the state's current state of emergency, initially declared by Gov. Gretchen Whitmer on March 24, 2020.

Whitmer vetoed S.B. 1253 on December 31, 2020, the last day of the legislative session.

Michigan Governor Gretchen Whitmer

PHOTO COURTESY AUSTIN_SLACK/FLICKR

Unchecked Imbalance

Some public health measures intended to slow the spread of COVID-19 are at odds with concerns about executive and legislative government power, says Michael VanBeek, director of research for the Mackinac Center for Public Policy.

"The issue is checks and balance, specifically about the legislature's ability to delegate its lawmaking power," VanBeek told *Health Care News*. "The Michigan Supreme Court ruled that the law that Gov. Whitmer was using to issue pandemic policies unilaterally was unconstitutional because it was an inappropriate delegation of power from the legislature to the executive office. The statute the health department is using suffers from the same problem the [state] Supreme Court found with the governor's law: it provides no real limitations on the duration or extent of how these powers may be used by the director of the health department."

S.B. 1253 would have set clearer guardrails on executive power in Michigan, says Samantha Fillmore, a state government relations manager for The Heartland Institute, which co-publishes *Health Care News*.

"This legislation is ultimately intended to set reasonable time limits on emergency orders issued in response to an epidemic or public health concern," Fillmore said. "With the sudden onset of the coronavirus pandemic, we saw many governors and state Departments of Health across the nation overextend and, in some instances, abuse their authority during states of emergency. Legislation such as S.B. 1253 has been proposed as a necessary check on this authority in Michigan."

"Growing knowledge on virus transmission, accompanied by the rollout of vaccines around the country, should sway lawmakers to feel more inspired than ever to regain power from overzealous lawmakers and government powers. Many can begin to see the light at the end of the tunnel with this and want to begin giving their constituents their lives back."

SAMANTHA FILLMORE
STATE GOVERNMENT RELATIONS MANAGER
THE HEARTLAND INSTITUTE

First, Do No Harm

Public health and economic prosperity go hand in hand, and the government should work with a light touch when interfering in people's lives, VanBeek says.

"They are intertwined tightly: you can't impact one without impacting the other," VanBeek said. "Lawmakers should limit their actions to policies directly related to helping ensure there is sufficient health care capacity to deal with the spread, but that's it. They should not be restricting people's behavior beyond that."

As vaccine distribution begins to ramp up in the United States, lawmakers should start thinking about how to return their states safely to some semblance of normality.

"COVID-19 was unpreceded in the sense that we had zero knowledge about the virus upon its sudden arrival in the United States," Fillmore said. "Growing knowledge on virus transmission, accompanied by the rollout of vaccines around the country, should sway lawmakers to feel more inspired than ever to regain power from overzealous lawmakers and government powers. Many can begin to see the light at the end of the tunnel with this and want to begin giving their constituents their lives back."

The lockdowns in Michigan have had limited effect in stopping the virus. Between March 1 and December 31, 2020, more than 500,000 Michigan residents contracted COVID-19. Almost 13,000 individuals in the state are confirmed to have died because COVID-19 during that time.

"I don't believe lockdowns will ever happen again," said Jeffrey Tucker, editorial director of the American Institute of Economic Research, on the Heartland Daily Podcast on January 4. "I think the damage has been so traumatizing that I fully expect that the political fallout from this—we haven't near seen it yet—is going to amount to be revolutionary.

"The governors that locked down are going to go down in disgrace," Tucker said. "A new generation of leaders is going to rise up who are specifically anti-lockdown, and I think it could lead to a real political alignment in this country in a way that long-term will be very good for the country."

Lessons of 2020

Public health does not necessarily have to come at the cost of massive government intrusion and the economic turbulence experienced by many in 2020, Fillmore says.

"Protecting public health has been at the forefront of every policymaker's mind throughout the coronavirus pandemic, but insulating the public health did not have to come with such devastating economic costs," Fillmore said.

The lockdowns have left tens of thousands of people without jobs and closed hundreds of small businesses. At 6.9 percent unemployment, Michigan has the tenth-highest jobless rate in the United States, according to the U.S. Bureau of Statistics.

"Yelp estimates that 60 percent of U.S. businesses that have closed since the start of the COVID-19 pandemic have shut down permanently," Fillmore said.

S.B. 1253 would have benefited Michigan residents without causing any bad or unintended consequences, Van Beek says.

"I cannot think of any downsides," Van Beek said. "It would have required that the people's representatives have a say in matters that could affect every resident in the state and not leave these important public health decisions up to an unelected bureaucrat."

Jesse Hathaway (**think@heartland.org**) *is a policy advisor for The Heartland Institute.*

Trump Leaves Legacy of Health Reforms

By Bonner Cohen

Several health care reforms implemented by President Donald Trump could be on the chopping block if the Biden administration follows through on plans to focus on government-directed expansion of coverage instead of providing choice to patients.

Some key Trump policies and systems that could face rollbacks are the following:

- Access to virtual medicine, including doctor consultations by phone, Zoom, and Skype
- Employer-funded accounts to pay for round-the-clock primary care
- Health Savings Accounts for chronically ill patients to help them manage their own care
- Expanded opportunities for Medicare plans to specialize and become centers of excellence in treating chronic diseases
- Insurance tailored to individuals and families through "short-term" insurance markets
- Mandatory posting of prices so patients can know what they will be charged in advance of treatment
- Waivers so states can take care of high-cost patients while lowering premiums for everyone
- Employer-provided personal and portable health insurance that travels with the employee from job to job
- Giving patients more control over electronic health data
- Reducing paperwork for Medicare providers
- Approving more generic drugs
- Allowing importation of prescription drugs from Canada
- Indexing Medicare drugs to the same prices foreign countries pay
- Repealing the tax on medical devices and health plans
- Paying physicians equally for Medicare services
- Expanding Medicare Advantage plan options
- Giving the terminally ill the right to certain treatments
- Repeal of the Obamacare individual mandate

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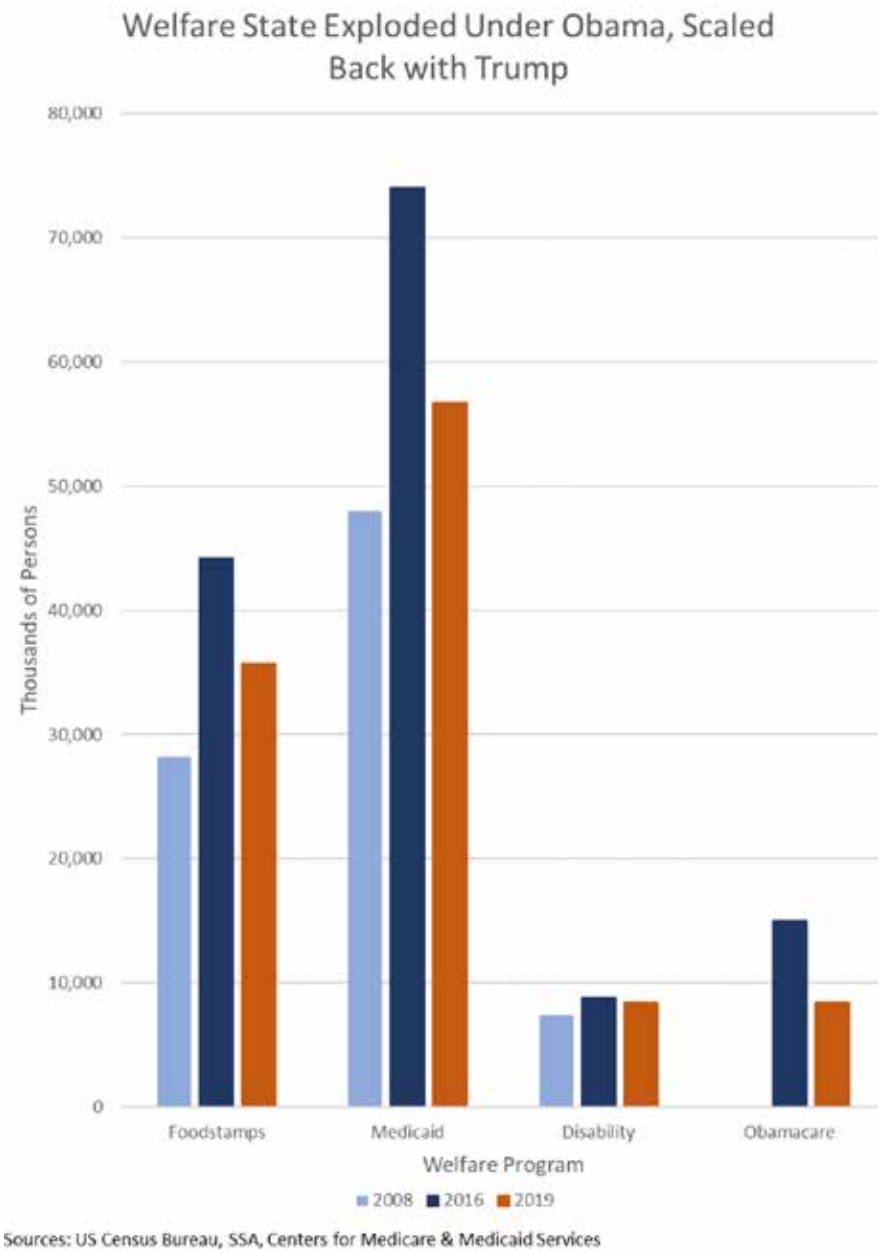
Biden: Obama II for the Welfare State?

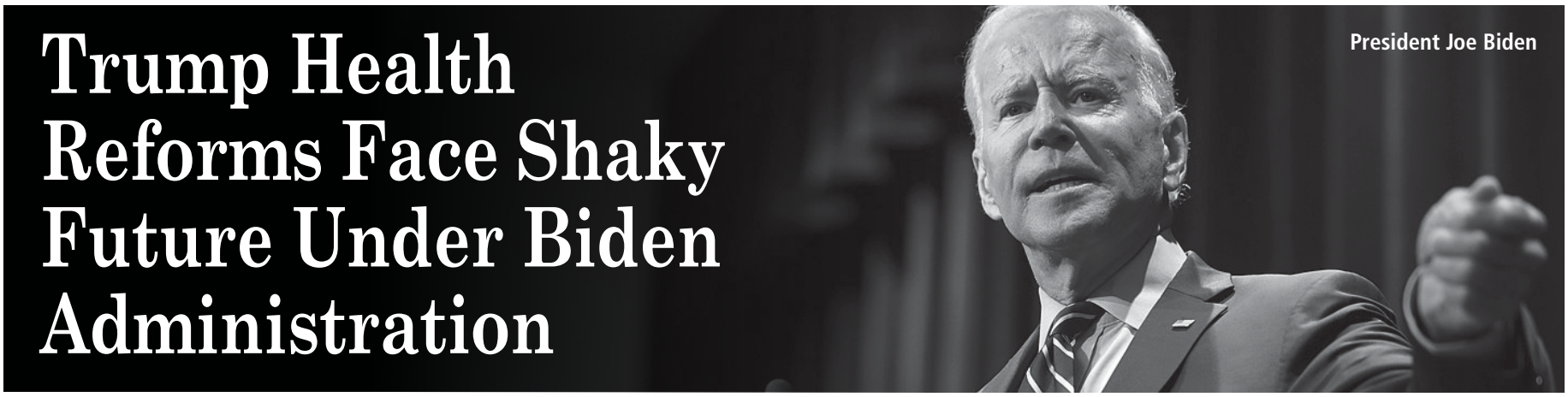
The United States could soon see a new era of the welfare state if President Joe Biden fulfills his promise to follow the record of the Obama administration, notes the Committee to Unleash Prosperity (CTUP).

The CTUP blog posted a graph showing how four of the nation's social welfare programs exploded in growth by the time President Barack Obama left office in 2017 and shrank two years into President Donald Trump's term.



Source: Committee to Unleash Prosperity, Issue #196, January 8, 2021. Reprinted with permission.

Trump Health Reforms Face Shaky Future Under Biden Administration



President Joe Biden

PHOTO COURTESY GAGE SKIDMORE/FLICKR

By Bonner Cohen

President Joe Biden has sent strong signals his administration will chart a new direction in health care policy.

Some signals have gotten wide attention, such as increasing testing and vaccine distribution under another COVID-19 relief package, this one set at $1.9 trillion, which Biden announced on January 14. Biden is also expected to ask all Americans to mask up for the first 100 days after his inauguration.

Media reports have paid less attention to equally significant proposals to lower the Medicare eligibility to age 60 and add a "public option" insurance plan on the Obamacare exchange. Biden might also undo health care reforms implemented by the Trump administration, especially those aimed at increasing choice in and access to the private insurance market (see related article, page 10).

"Biden's plans to repeal the 'firewall' between employer-sponsored health plans and Obamacare exchanges would likely result in a mass migration of Americans away from employer coverage. Given that Biden's running mate, Kamala Harris, previously expressed her desire to 'move on' from private health insurance entirely, his planned moves look like the precursor to the full government takeover of health care the Left so desperately desires."

CHRIS JACOBS
PRESIDENT AND CEO
JUPITER GROUP

Expects Government Takeover

Health insurance could be in the president's crosshairs, says Chris Jacobs, president, and CEO of the Jupiter Group.

"Biden's plans to repeal the 'firewall' between employer-sponsored health plans and Obamacare exchanges would likely result in a mass migration of Americans away from employer coverage," Jacobs said. "Given that Biden's running mate, Kamala Harris, previously expressed her desire to 'move on' from private health insurance entirely, his planned moves look like the precursor to the full government takeover of health care the Left so desperately desires."

Biden's proposals are "surprisingly illiberal," says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"Biden proposes to subsidize the [Obamacare] premiums of the 40 percent of higher-income families who currently get no subsidy in the health insurance exchanges," Goodman said. "As a percent of income, wealthy buyers would get the same help from government as the near-poor."

Medicaid for More

Biden's plan to lower the eligibility age for Medicare to age 60 would benefit a wealthy age group, Goodman says.

"According to the most recent *Current Population Survey*, this age group has above-average income and above-average wealth," Goodman said. "Moreover, of the almost 30 million people in the United States who are currently uninsured, only about 1.7 million are seniors. If these people buy their own health insurance and have below-average incomes, they already are entitled to the same subsidies as everyone else gets. If they make too much income to qualify for subsidies under current law, they face premiums that are kept artificially low. In fact, relative to actuarily fair premiums, this age group is the most favored of all."

Rollback Options

In choosing how to roll back reform initiatives, the Biden administration will have several options. Like the Trump administration, it can use executive orders and the administrative rulemaking process to make such changes. For example, President Donald Trump's HHS rule allowing states to apply for block grants to help fund Medicaid could be scrapped administratively. However, any attempt to do away with Trump's rules administratively would likely be subject to lawsuits that could considerably delay overturning them.

Biden administration officials will also have to decide whether they want to allow Medicare patients to continue to use telemedicine after the pandemic subsides. Removing the option could prove very unpopular with seniors and patients with disabilities and would likely face stiff resistance.

The Biden administration could also avail itself of the Congressional Review Act (CRA). Enacted in 1996, the CRA is an oversight tool Congress can use to pass legislation to overturn a rule issued by a federal agency. Under the CRA, if a "Resolution of Disapproval" is passed by both houses of Congress and signed into law by the president, the rule is overturned. The Resolution of Disapproval is not subject to a filibuster in the Senate and needs only to receive a majority vote from all members present. The CRA has been used to overturn a total of 17 rules, 16 of which were eliminated in the 115th Congress (2017-2018).

Legislative Obstacles

Overhauling the health care system through legislation, the path chosen for enacting Obamacare in 2010, is another option. Democratic losses in the House in November and an almost evenly split Senate will make passing a comprehensive measure difficult and could even prove tricky for efforts to nullify Trump's rules under the CRA.

The widely unpopular practice of surprise medical bills could be a lot easier to curtail. On December 11, key House and Senate committees announced a bipartisan agreement on legislation establishing a framework for resolving billing disputes between insurers and providers without increasing premiums for patients.

Key Player Wants Single-Payer

A key player in Biden's new direction will be former California Attorney General (AG) Xavier Becerra, his selection for secretary of the Department of Health and Human Services (HHS).

Becerra has neither a medical background nor any experience in running a large bureaucracy like HHS, but he has never been shy about expressing his views on health care. As California's AG, Becerra brought many—mostly unsuccessful—challenges to Trump administration regulatory moves aimed at fostering a patient-focused approach to health care.

For more than two decades, Becerra served in the U.S. House of Representatives as an enthusiastic supporter of imposing a single-payer system, long before Medicare for All gained currency among Democrats.

After congressional Republicans failed to "repeal and replace" the Affordable Care Act when they had majorities in both houses of Congress during the first two years of Trump's term, the White House relied on a series of executive orders and agency regulatory actions to bring about reforms (see related article, page 10).

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STUDY

DNR Orders Associated with Increased COVID-19 Deaths

By Bonner Cohen

A patient's do-not-resuscitate (DNR) status significantly increases their risk of death from COVID-19, a study of an often-overlooked chapter of the nation's experience with the coronavirus pandemic has found.

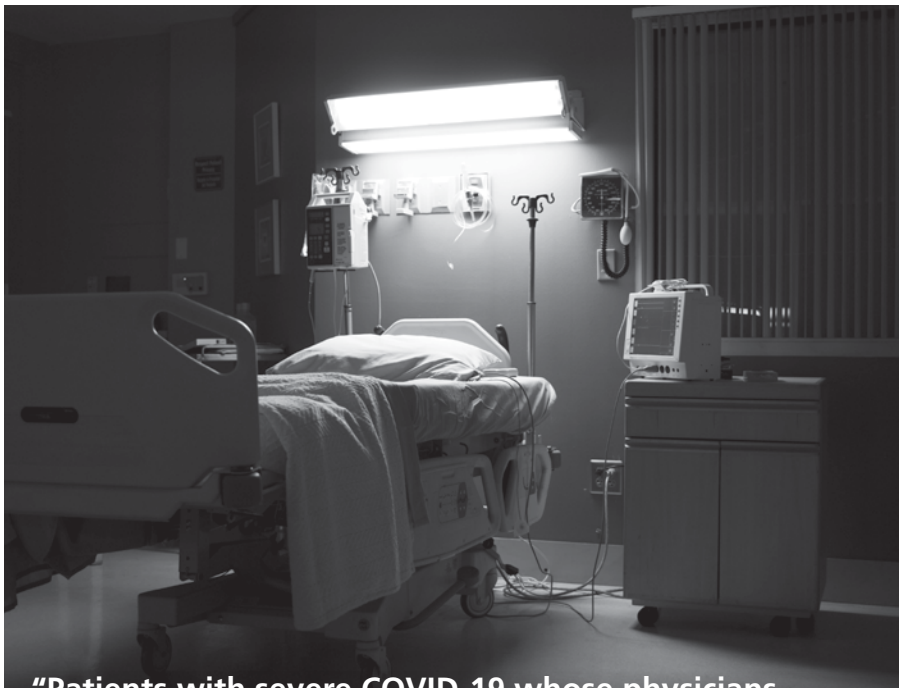
The study, published in *Clinics in Dermatology* on November 28, is a retrospective, observational cohort analysis of coronavirus patients admitted to two New Jersey hospitals from March 15 to May 15, 2020 who had or developed COVID-19. The study was conducted by a team of physicians and public-health experts.

All told, 1,270 patients were studied. Of the 640 patients who died, 89.1 percent had a DNR order at the time of admission and 10.9 percent did not. Of the 630 patients who survived, 28.6 percent had a DNR order while 71.4 percent did not.

"COVID-19 DNR patients had a significantly higher mortality rate compared to COVID-19 non-DNR patients," the study found.

A DNR may influence treatment decisions, the study authors say.

"Patients with severe COVID-19 whose physicians feel they need such measures short term to treat the disease may be discouraged from offering them if the patient has a DNR order," the study states. "This may unnecessarily negatively impact patient care and increase mortality in COVID-19 patients."



"Patients with severe COVID-19 whose physicians feel they need such measures short term to treat the disease may be discouraged from offering them if the patient has a DNR order. This may unnecessarily negatively impact patient care and increase mortality in COVID-19 patients."

***CLINICS IN DERMATOLOGY* STUDY**

Linked to Health Problems

A DNR is a written instruction signed by an individual telling physicians and health care providers not to perform cardiopulmonary resuscitation (CPR), a lifesaving emergency technique that restores heart and lung function. The study suggests the DNR status "may be a proxy for more severe illnesses."

"DNR status is often linked to patients with severe illness, advanced age, poor disease prognosis, and deteriorating health status with impending death," the authors state. "Data are lacking on survivability of inpatient cardiac arrest for COVID-19 patients."

Data collected for the study showed DNR patients were significantly older, more often male than female, and had more comorbidities or preexisting conditions.

The authors note one explanation for the higher death rates among COVID-19 patients with DNRs is that the individuals died because they were not resuscitated.

"Another hypothesis is that in the face of rapid clinical deterioration, DNR patients may be more likely to be placed on comfort care (hospice) compared to non-DNR patients," the study states. "However, due to the retrospective study design, reasons for a DNR order cannot be determined."

Pressured to Sign?

Hospital policies may have been an important factor in raising the mortality rate, says Twila Brase, R.N., Ph.N., president and cofounder of the Citizens' Council for Health Freedom and a policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"First, hospitals separated Covid-19 patients from their protective families," Brase said. "How many sick and vulnerable patients felt pressured to sign DNR orders without a family member in their corner?

"Second, *The Wall Street Journal* reported in December that hospitals initially ventilated patients very early, not for the patient's benefit but to try to control the epidemic and save other patients," Brase said. "Mechanical ventilation is dangerous. Upwards of 80 percent of ventilated patients died. How many scared patients were asked to sign DNR orders before they were sedated and intubated? We'll never know."

A report in the U.K *Daily Mail* on December 4 describes such a scenario. A "frailty nursing practitioner" paid a visit to a 93-year old woman who was healthy and living independently. The next day, the woman received a letter with a DNR signed by the official who visited her. The newspaper said it received hundreds of similar reports.

Deadly Government Effect?

A blog item on December 8 by the Committee to Unleash Prosperity said the push to sign DNRs is not unusual when government plays a larger role in health care, as it has with the National Health Service in the U.K.

"We have warned that one inevitable consequence of the march toward government-run health care will be a triage system of death panels to reduce costs—where the government, not families and loved ones, decides when to pull the plug," the blog post states.

A report in the *Journal of the American Medical Association* (*JAMA*) in March 2020 encouraged health care providers to issue unilateral DNRs for patients without their authorization "to reduce the risk of medically futile CPR to patients."

That report also suggested the use of "informed assent," instead of "informed consent," notes Brase. Informed assent is when an individual gives someone authority to make decisions for them before they become incapacitated.

"This process is used to guide families into not protesting the hospital's plan to implement a DNR order," Brase said. "How did this suggestion influence physician discussions with families far from their loved one's bedside? The study of COVID-19 hospitalizations in New Jersey can be seen as an examination of where such blanket DNR policies can lead."

The authors of the New Jersey study state the push to promote DNR orders for all COVID-19 patients "has created wide public outrage" and "certifying COVID-19 as the cause of death has driven up statistics of the pandemic and affected healthcare decisions in the U.S. and globally."

COVID-19 Changes Dynamic

Unlike a terminal illness, where patients and families may have months to consider outcomes, the rapid onset of life-threatening COVID-19 puts families, patients, and physicians in an unusual position, the study notes.

"DNR status may be requested by patients and/or their families to avoid prolonged life support, including application of a respirator, at the end of life when there is little or no expectation that this will be followed by a more normal existence," the study states. "Treatment for severe COVID-19 may require such measures as well, but usually for a much shorter interval, days or weeks, usually with a good expectation of a normal or near-normal existence on recovery."

Bonner R. Cohen, Ph.D., **(bcohen@nationalcenter.org)** *is a senior fellow at the National Center for Public Policy Research.*

INTERVIEW

Doctor: Governments, Health Care Industry Taking Wrong Approach in Treating COVID-19

Peter McCullough, M.D., M.P.H., is an internist, cardiologist, and epidemiologist at Baylor University Medical Center who has been leading the charge on early, at-home treatment for COVID-19. McCullough was one of 10 physicians who testified before a U.S. Senate committee on the issue. McCullough explained to Health Care News why the nation's existing approach to caring for COVID-19 has been misguided. McCullough says his views are his own and not necessarily those of his institutions.

Health Care News: What does the Biden administration need to know to stop the coronavirus?

McCullough: As a doctor, I've never seen such an event as this come sweeping through in our current medical history. The United States is leading the world in test-positive cases and deaths per million population. It seems from the beginning, on virtually every aspect of pandemic control, we have made gross errors. And we don't seem to be learning at all from other countries around us.

To my knowledge, in both the Trump and Biden administration task forces, there's not a single individual who has any experience in treating outpatient COVID-19.

Health Care News: Has there been any response to the five hours of testimony on Capitol Hill on early COVID-19 treatment?

McCullough: We have had now nearly a year of constant media attention to this problem and the protocol goes something like the following. There'll be an update on the coronavirus. There'll be mention of some bad statistics—more cases, more hospitalization, and more deaths. And then there'll be a media expert, and that media expert will immediately pivot and blame the victim and make some comment regarding social distancing or not wearing masks, not following various lockdown ordinances.

There's never any mention of treatment. There's never any mention of what to do when given a positive test result. It's almost as if these bad events fall out of the sky.

It's stunning because in any other medical condition—heart attack, breast cancer, pneumonia, you name it—we have detailed information sheets on what to do in terms of early treatment.

In COVID-19, shockingly, a year into this, we have no information available for the public. Sen. Ron Johnson (R-WI), who was the majority chairman of the Senate Committee for Homeland Security and Governmental Affairs at the end of last year, held two hearings to break the information to the public on the treatment of COVID-19 [on November 19 and December 8]. I was one of the lead presenters. We had world-renowned experts summarizing the information on early COVID treatment with a goal of getting this information to the public, and there was a complete block[ade] of major media.

Health Care News: Are there any physicians using the drugs you've discussed, such as hydroxychloroquine and ivermectin, to treat COVID?

McCullough: The doctors who have voluntarily taken on outpatient COVID are very much heroes. They've risked their clinics. They've risked their lives. They've become incredibly busy with so many sick patients with COVID. The vast majority of doctors say they don't treat COVID. And that's a very short conversation. There's no advice.

[Patients] literally just sit at home, wait until they get sick enough and go to the hospital, get put in isolation, and either die in the hospital or have a prolonged stay with all kinds of various procedures and complications. It is absolutely terrifying.

The detractors have come up with innumerable reasons not to treat COVID early. One of the most common ones is, "We don't have large clinical trials," or, "We don't have conclusive clinical trials." I'm an expert in clinical trials. We have zero conclusive randomized clinical trials (RCT). We would need a study of about 20,000 patients. We could have done that in March and April, but it wasn't done. And as soon as our pharmaceutical and National Institutes of Health, FDA [U.S. Food and Drug Administration] and CDC [U.S. Centers for Disease Control and Prevention] complex understood that this disease could be amenable to a vaccine, all hopes of early treatment were dropped. There is zero hope that we'll have any randomized trials on early treatment.

Health Care News: We have a large body of observational studies on early COVID-19 treatment. During testimony, Dr. Harvey Risch of Yale stated modern statistical analysis can look at this type of data and come very close to high-quality RCTs. What do we know?

McCullough: The reality is COVID-19 is a very treatable illness. My colleagues and I have reviewed many studies, most of them coming from outside the United States, and have assembled scientific information in a series of publications. Our work has shown that a sequenced, multidrug approach using off-label intracellular anti-infectives as a first layer, then corticosteroids, then blood thinners, on top of a base of nutraceuticals, which help protect against tissue injury, in fact works. It works so successfully it reduces hospitalization by about 85 percent.

We would have avoided 85 percent of the hospitalizations if this early treatment initiative had been undertaken at the outset.

We have to remember we are dealing with a virus. Single drugs don't work against viruses. We need a sequenced, multi-drug approach.

Health Care News: These existing drugs you suggest for treating COVID have been used for decades. Doctors prescribe drugs "off label" all the time. Why do you suppose there is the heavy hand of government preventing that for this pandemic?

McCullough: The drugs are all generically available. They're all safe and effective. They would be of no interest to large pharmaceutical [companies] working with Operation Warp Speed. In fact, they'd be viewed as competitive to vaccine manufacturers. If we had early, effective treatment, the hospital administrators wouldn't have this deluge of patients.

You can see there's an alignment of stakeholders against early treatment. The only stakeholder that wants early treatment is the patient, who wants to avoid hospitalization and death.

INTERNET INFO

Peter McCullough, M.D., *et al*., "Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 invection (COVID-19), *Reviews in Cardiovascular Medicine*, December 2020, Vol. 21: **https://rcm.imrpress.com/EN/10.31083/j.rcm.2020.04.264**

"What President Biden Needs to Do to Control COVID-19; Guest, Peter McCullough, M.D., *The Heartland Daily Podcast*, January 19, 2021: **https://podcasts.apple.com/us/podcast/what-president-biden-needs-to-do-to-control-covid-19/id557620400?i=1000505855115**

Mask Mandates Persist Despite Cautionary Article Early in Pandemic

By AnneMarie Schieber

An article published in the *New England Journal of Medicine* (NEJM) in May is getting renewed attention for having stated "wearing a mask outside health care facilities offers little if any, protection from infection."

Thirteen days after publication, the researchers wrote a clarification to that line, in a letter to the editor stating, "as the rest of that paragraph makes clear, we intended this statement to apply to passing encounters in public spaces, not sustained interactions within closed environments."

The remainder of the paragraph states the following: "Public health authorities define a significant exposure to COVID-19 as face-to-face contact within six feet with a patient with symptomatic COVID-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 30 minutes). The chance of catching COVID-19 from a passing interaction in a public space is therefore minimal.

In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic."

Still 'Pro-Mask'

Author Michael Klompas, M.D., M.P.H. of the Harvard Medical School, told *Health Care News* he and his fellow writers felt the need to write the response because several readers took the statement out of context and twisted its meaning.

"[The article] was picked up by an anti-mask Twitter feed," Klompas said. "The intent was to take our article out of context and was not a reflection of where current knowledge stands."

Klompas says the letter to the editor was not a retraction. In fact, Klompas says he and the other writers were not pressured to write the letter of clarification and he stands by the article today.

"There was no pressure," Klompas said. "My colleagues and I are very pro-mask."

Despite the article in question and growing evidence showing masks alone have little effect in stopping transmission of the virus that causes COVID-19, governments all over the world have ramped up mask mandates. In fear of fines or lawsuits, U.S. businesses and private organizations have ordered customers, employees, and visitors to mask up.

Intention: Increase Masking

The May 21 article, titled "Universal Masking in Hospitals in the Covid-19 Era," was written to increase masking, not decrease it, and to review universal masking in health care settings, Klompas says.

"The state of knowledge at the time was based on influenza studies," Klompas said. "It was difficult to find data proving the impact of masking. Our letter written to the NEJM was to clarify that."

New studies from the U.S. Centers for Disease Control and Prevention (CDC) and researchers in Denmark have shown masks have had little effect in stopping transmission of the COVID-19 virus, but Klompas says it is important to note the context.

"[The Danish study] looked at virus coming in, not addressing virus coming out," Klompas said. "Plus, the rate of viral infection in [Denmark] at the time of the study was very low and the only way they could test protection was with antibody studies, which are subject to false positives and negatives and corrupt the signal."

Limited Value

Mask mandates in the United States have been in place for months, and cases are at peak levels.

Klompas acknowledges the limitations of masks in stopping a virus.

"There are many factors related to transmission," Klompas said. "Masks are one factor. A mask alone won't be perfect protection."

Masks also force users to touch their faces more often, but Klompas says he doesn't think that is a reason not to recommend masks.

"When I put on a mask, I'm not putting my hands inside my mouth or up my nose," Klompas said. "I put the loops around my ears, not licking the mask. I'm a bigger worrier that you have a cloth mask and never wash it and that being a breeding ground for bacteria. I haven't, however, seen much evidence of harm from that."

Masks As 'Talismans'

Klompas and the coauthors state in their article there is a purpose for masks unrelated to providing a shield against a virus.

"It is also clear that masks serve symbolic roles," the authors write. "Masks are not only tools, they are also talismans that may help increase health care workers' perceived sense of safety, well-being, and trust in their hospitals. Although such reactions may not be strictly logical, we are all subject to fear and anxiety, especially during times of crisis."

AnneMarie Schieber (amschieber@heartland.org) *is the managing editor of* Health Care News.

"The state of knowledge at the time was based on influenza studies. It was difficult to find data proving the impact of masking. Our letter written to the NEJM was to clarify that."

MICHAEL KLOMPAS, M.D.
HARVARD MEDICAL SHOOL

INTERNET INFO

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Parents, Others Push Back Against Mask Mandates for Children

By Ashley Bateman and AnneMarie Schieber

Parents, students, and employees are ramping up complaints about mask mandates, questioning the effect masks are having on physical health and noting the psychological and social damage that have resulted from extensive use of face coverings.

Mask mandates for children are getting particular attention. In November, the activist organization Citizens for Free Speech (CFFS) developed an online forum for parents and caregivers to share stories of the negative effects of children having to wear masks.

The website, nomasksforkids.com, has divided complaints into separate categories: psychological, neurological, dermal, and dental; and eye, ear, and breathing.

The complaints describe children suffering from headaches, skin reactions, allergies, anxiety, mouth sores, and breathing difficulties. Reports also describe children who resist wearing masks being segregated and feeling like outcasts.

The site also links to several studies questioning the efficacy of masks against viral infections. The goal of the site is to collect as many verifiable stories of mask trauma as possible, says CCFS Director Patrick Wood.

"The suffering of a few kids might not generate the attention or actions required, but hearing the first-hand accounts of the suffering of thousands will force the powers that be to do something about it," Wood said in a news release.

Within two hours of the site going live, 70 incidents of mask harm to children were reported.

Researchers Interested

The site is going strong today, Wood told *Health Care News*.

"Complaints continue to come in, and we have received contacts from researchers who want to investigate these events," Wood said. "That, we didn't expect."

Researchers are looking at the impact of masks on health. A German preliminary study published this fall by Research Square found that most students wearing masks reported negative health impacts. Nearly 70 percent of the 25,000 children surveyed said they experienced negative physical, psychological, and behavioral health effects of mask-wearing, according to parents and caregivers.

The data could prove helpful in several lawsuits that have emerged to challenge mask mandates, particularly for children. In September, two dozen parents filed suit against the state of Ohio for requiring K-12 students to wear masks. A Catholic school in Michigan sought injunctive relief from having to require kindergarteners to wear masks for extended periods of time, even though the school added more safety measures than required by the U.S. Centers for Disease Control and Prevention.

Children and Herd Immunity

With children proving the least likely to suffer the worst complications from COVID-19, including death, there is growing opinion the nation is missing an opportunity to build up natural "herd" immunity from the SARS-COV-2 virus. Masks and school lockdowns make that difficult.

Early in the pandemic, Knut Wittkowski, a biostatistician with the Department of Biostatistics, Epidemiology, and Research Design at The Rockefeller University, recommended schools be kept open for this very reason.

In an interview with the Press & The Public Project in April in which he discussed his March 2020 paper, Wittkowski said the only thing that stops respiratory diseases is herd immunity.

"About 80 percent of the people need to have had contact with the virus, and the majority of them won't even have recognized that they were infected, or they had very, very mild symptoms, especially if they are children," Wittkowski said. "So it's very important to keep the schools open and kids mingling to spread the virus to get herd immunity as fast as possible, and then the elderly people, who should be separated, and the nursing homes."

Says Surge Was Preventable

Wittkowski says herd immunity can protect communities for years, and he says his suggestions would have averted the latest surge in cases.

"If we had herd immunity now, there couldn't be a second wave in the autumn," Wittkowski said in the April interview. "Herd immunity lasts for a couple of years, typically, and that's why the last SARS epidemic we had in 2003 lasted 15 years."

The Rockefeller University disavowed Wittkowski's views on April 13.

Ashley Bateman (**bateman.ae@googlemail.com**) *writes from Alexandria, Virginia. AnneMarie Schieber* (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

Parents Get Options to Escape School Lockdowns

By Ashley Bateman

President Donald Trump approved the use of grants to help cover the costs of in-person education, including enrollment in private schools, allowing parents to get their children back in classrooms.

Trump's December 28 executive order allows states to use Community Service Block Grants (CSBGs) to give emergency K-12 scholarships to disadvantaged children who have been locked out of public schools in response to the pandemic. The grants can cover a multitude of schooling options, such as private school, homeschooling, microschooling, learning-pods, special education services, and tutoring.

"All families should be empowered to make the decision that is right for their own circumstance," Trump stated in a press release.

In the $900 billion COVID relief bill, Congress provided $2.75 billion in funds for private K-12 schools (and $54.3 billion to public schools) but prohibited the private school money from going directly to families. CSBGs are normally distributed through organizations that help low-income families, but this is the first time they may be used for private school tuition. In fiscal year 2020, CSBG funds totaled nearly $1.7 billion.

Lockdowns and Child Development

Lockdowns and school closures have adversely impacted student achievement, especially among special-needs and low-income students.

The executive order cites a variety of research, including one projection that if classes did not resume by January 2021, students from low-income households would lose more than one year of learning and suffer an average loss of between $61,000 and $82,000 in lifetime earnings, the equivalent of a full year of full-time work.

In the months following the outbreak of COVID-19, a study by Renaissance found math scores, among five million students assessed, fell by seven percentage points between the Fall of 2019 and Fall of 2020. The difference was more pronounced for students of color, those in high poverty populations, those who attend government schools, and those living in rural or small towns, the study found.

In a survey conducted by the Center for Reinventing Public Education, Black and Latinx students reported greater obstacles to their virtual learning than their peers, which resulte in depression, stress, and anxiety. Record-high numbers of failing grades and absenteeism were also reported.

Ashley Bateman (**bateman.ae@googlemail.com**) *writes from Alexandria, Virginia.*

STUDY

Healthy Education: School Choice Keeps Teens Happier

By Harry Painter

School choice and adolescent mental health are closely linked, a first-of-its-kind study finds.

The study, published online in the journal *School Effectiveness and School Improvement* on December 3, found the suicide rate in the 15- to 19-year-old age bracket dropped by 10 percent in states that have adopted charter school laws and that private schools can reduce mental health problems during the adult years. Authors Corey A. DeAngelis and Angela K. Dills also looked at the effects of state vouchers for private schooling and found no significant effect on suicide rates.

This trend is occurring against a backdrop of skyrocketing suicide rates for that age group. The U.S. Centers for Disease Control and Prevention (CDC) finds that between 2007 and 2015, suicides doubled among 15- to 19-year-old females, and male suicides increased by 30 percent. The pandemic lockdowns may be making suicide rates worse. Citing a survey conducted over the summer, the CDC reported 10.7 percent of adults aged 18-24 had contemplated suicide in the past 30 days.

How School Choice Helps

It's not clear yet exactly what factors affect the correlation between charter school programs and decreased suicide rates.

"There are a variety of potential mechanisms," Dills, an economist at Western Carolina University, told *Health Care News*. "School choice allows families to find a school that fits their child's needs better, providing a better match between students and schools."

There may also be some impact from families withdrawing children from standard government schools to avoid bullying, Dills says. A survey by the National Center for Education Statistics shows safety is a top priority for parents in making education decisions, and bullying would fall into that safety category.

Giving teens some control may also be a factor, Dills says.

"One possible mechanism is that school choice acts as a release valve—students can more easily leave bad schooling situations, [which would improve] mental health," Dills said.

Improves Rates for All

Market dynamics could also be at play and have some spillover effect on conventional schools. Interestingly, the effect on suicide rates occurred statewide, not just for students enrolled in private or charter schools.

"Competitive effects from school choice improve the school climate in all schools," Dills said.

Public schools could be "increasing the focus on mental-health-improving policies," Dills said.

Charter schools and private schools also have more flexibility in administration, curriculum, discipline, and customization. When focusing on attracting students, the schools have to be more accountable for teacher performance, says Dills.

"Schools of choice—charter schools, private schools—have more leeway to consider curricula and/or school climate choices that focus on socio-emotional skills and improving interactions among the students," Dills said.

Although the study does not prove causal effects of school choice on adolescent suicide rates, other explanations for the declines—such as states adopting charter school laws in response to declining suicides—are "unlikely," Dills says.

Pandemic Redefining Schools

Children and teens spend so much time in school that it is hard to separate public educational policies from overall child development, including physical health. Schools also assist with a child's physical well-being. Children have assured meals in school through federal lunch programs, many schools have mandatory physical fitness and education programs, and schools can also be a watchdog for childhood neglect and abuse.

The pandemic lockdowns have removed many of these factors from the educational landscape. School closures around the nation have forced children into at-home, online classrooms or "pandemic pods" that limit physical contact among students. Surveys indicate parental opinion of local schools has declined during the lockdowns.

The lockdowns have also significantly increased public approval of school choice, says study coauthor DeAngelis, director of the school choice program at Reason Foundation and an adjunct scholar at the Cato Institute.

"A nationwide survey from Real Clear Opinion Research found that support for school choice has surged by 10 percentage points since April—from 67 percent to 77 percent," DeAngelis said.

"Another national survey from EdChoice similarly found that support for all types of school choice jumped since last year, with 81 percent of the general public now supporting education savings accounts," DeAngelis said.

Virtually Informed

One difference between in-person schooling and virtual schooling has been an increase in parental scrutiny of academic performance. That phenomenon has led some schools to take measures to prevent parents from observing their children's virtual classes.

"Families have been getting a bad deal when it comes to K-12 education for far too long, and it's clearer now more than ever. Families are realizing that there isn't any good reason to fund institutions when we can fund students directly instead."

COREY A. DEANGELIS
DIRECTOR OF THE SCHOOL CHOICE PROGAM
REASON FOUNDATION

"Virtual schooling has provided many parents with more information about their children's schools' curriculum and teachers," Dills said. "Many families have used the disruption as an opportunity to try alternate forms of schooling."

Those alternatives include homeschooling, virtual private schools, and education pods.

"For some families, learning about their options and experiencing them will lead to permanent changes in schooling choices," Dills said.

"Families have been getting a bad deal when it comes to K-12 education for far too long, and it's clearer now more than ever," DeAngelis said. "Families are realizing that there isn't any good reason to fund institutions when we can fund students directly instead."

Harry Painter **(jharrypainter@gmail.com)** *writes from Brooklyn, New York.*

INTERNET INFO

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Health Insurer Demands Doctors Accept 'Woke' Training

By AnneMarie Schieber

Blue Cross Blue Shield of Michigan (BCBSM) has ordered all the physicians it credentials to undergo a training program to reflect on their "unconscious bias" against people of color and to learn "bias busting strategies."

Physicians must complete the "Stanford Unconscious Bias in Medicine" training module by June 25 or face "current and/or future BCBSM value-based reimbursement." In addition to teaching doctors how to identify their "implicit bias" and how to develop "bias busting strategies" in the medical environment, the course teaches doctors how to correct "personal unconscious biases" in everyday life and that "unconscious bias" affects the people they encounter in their jobs.

BCBSM released a statement to *Health Care News* which reads in part, "The unconscious bias education program is one program that we have to address health care delivery and the prevalence of health and health care disparities in our communities. The outreach to physicians and their care delivery teams and [their] office staff is in its early stages and initially focuses on increasing awareness of how bias can show up in health care delivery. We will continue to work closely with our provider partners to address health and health care disparities and improve the quality of care for our members."

The company did not say whether there were any specific incidents of racism that led to the decision.

"How will a doctor's 'improved attitude' shorten her patient's wait to see a specialist or to have physical therapy close to home? What implicit bias training really does is give the Left a false sense of moral superiority and satisfaction because in their minds they did something to address the problem. Socialist solutions, like implicit bias training, end up harming those who they claim to help."

GABRIELA EYAL, PH.D.
CLINICAL PSYCHOLOGIST

Woke Training for Licensure

The training mandate could be a first step toward governments requiring woke training for all doctors who wish to obtain or keep a medical license. Gov. Gretchen Whitmer of Michigan alluded to that possibility on July 9 when she signed an executive director to "improve equity across Michigan's health care system."

The order directs the state's licensing board to start writing up rules requiring "implicit bias" training for obtaining and renewing licenses and the registering of licenses of other health care professionals. The state's news release mentioned fallout from the COVID-19 pandemic as the main reason for the requirement.

"As of July 5, Black Michiganders represented 14 percent of the state population, but 40 percent of confirmed COVID-19 deaths in which the race of the patient was known," the news release stated. "Covid-19 is over four times more prevalent among Black Michiganders than among white Michiganders."

Whitmer has close ties to BCBSM. Her father was the company's CEO for 18 years, and employees raised $145,000 in funds for her election campaign, according to an article in the Detroit *Metro Times* on August 2, 2018.

Michigan would not be the first state to require bias training for health care licensees. On October 2, 2019, Gov. Gavin Newsom of California signed Assembly Bill No. 241 into law. The bill requires physicians, surgeons, physician assistants, and nurses to undergo "implicit bias" training by January 1, 2022. Beyond that, the new law mandates continuing education include such training in its curriculum. Medical professionals must complete 50 hours of continuing education every two years in California.

Seen As a PR Scheme

Training health care professionals to identify and address bias is attacking what is arguably a hypothetical problem, says Gabriela Eyal, Ph.D., a clinical psychologist in Michigan. The BCBCM requirement does not yet apply to non-physicians but Eyal wanted to speak out after working in various capacities with low-income and hard-to-serve populations in the United States and for several years abroad in a socialized health care system.

"There has been a narrative to attribute the disparity to what has been labeled systemic racism and implicit bias in healthcare," Eyal said. "But will this awareness and training do anything for the minorities and the disadvantaged? Not really. If anything, they will do more harm than good. The concept is being used cynically as a fig leaf as the Left continues to neglect those they claim to help."

Eyal says the primary reason why blacks have died from COVID-19 more than whites is because of their poorly served urban neighborhoods. Many urban residents have to travel long distances, often using public transportation, to buy food, pick up medication, and see a doctor. Maintaining healthful lifestyles can be a challenge.

"Consequently, there is a higher incidence of chronic diseases like type 2 diabetes or high blood pressure, which are in turn poorly managed," Eyal said.

'A False Sense of Moral Superiority'

Such residents often rely on Medicaid for health care, which creates additional problems similar to what Eyal witnessed in socialized health care programs.

"It is very difficult to find a primary care physician as it is, let alone one that accepts Medicaid," Eyal said. "When they do eventually find a primary care physician, Medicaid patients end up with a 15-minute visit conducted by rushed doctors who have to spend more than 50 percent of their time wrestling with electronic health records instead of providing direct care to patients. Most likely, those fifteen-minute visits will result in a referral to one or more specialists. But, alas, the wait time to see a specialist for Medicaid recipients is months long, at times a year or more."

Medicaid enrollees often seek primary care in emergency rooms, which costs the taxpayers much more, Eyal says.

"With a Medicaid card, a person can see a doctor for free in the emergency room after a few hours' wait instead of weeks or months as an outpatient," Eyal said.

These are the real causes of racial disparities in health care, Eyal says.

"How will a doctor's 'improved attitude' shorten her patient's wait to see a specialist or to have physical therapy close to home?" Eyal asked. "What implicit bias training really does is give the Left a false sense of moral superiority and satisfaction because in their minds they did something to address the problem. Socialist solutions, like implicit bias training, end up harming those who they claim to help."

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

States Ease Doctor Shortage by Recognizing Foreign Medical Licenses

By Madeline Pelzer

States are beginning to make it easier for foreign-born doctors to help reduce the widespread physician shortage, which has been made worse by the COVID-19 pandemic.

New Jersey and New York have temporarily eased some of their licensing requirements to allow physicians trained in other countries to practice in their states.

It's a smart move, says Sally Pipes, president and CEO of the Pacific Research Institute.

"Welcoming more immigrant doctors to the United States is one way we can begin to narrow [the physician] shortage," Pipes said. "While it's important to maintain high quality standards when determining who should be able to practice in the United States, we shouldn't prevent competent physicians from coming here to supply the labor that the market is clearly demanding."

One Physician's Experience

Maqbool Halepota, M.D., an Arizona-based oncologist who trained abroad, says he had to go through enormous hoops to practice in the United States.

Halepota graduated from medical school in his native Pakistan and completed a residency at the Jinnah Postgraduate Medical Centre, becoming a specialist in physical medicine and rehabilitation. Halepota supervised the only artificial limb fitting institute serving Pakistan and neighboring countries, in addition to teaching at his alma mater. When Halepota came to the United States for greater opportunities in the field, he faced a host of roadblocks.

"In order to pass the exams and get into the system in the U.S., I had to take so many steps back," Halepota said in a Cato Institute webinar on August 5. "I feel on the average I lost maybe half a decade of my life."

Jumping Through Hoops

Foreign physicians who seek to practice in America must wade through a bureaucratic approval process dating back to the 1950s.

Graduates of medical schools in other countries are required to submit paper copies of their application for an H-1B visa for individuals in highly skilled professions, and these forms can be hundreds of pages long.

The H-1B visa also bars doctors from changing employers, providing care in other states, or practicing medicine that doesn't fall under their approved specialty. Federal law also makes things difficult for foreign medical students doing their residencies here.

Those on J-1 visas must return to their home countries for at least two years before being able to apply to return to the United States, with limited exceptions.

"State licensing boards require international medical school graduates who have completed post-graduate specialty training and are licensed to practice in other countries to repeat their entire post-graduate training in an accredited U.S. institution before receiving a state medical license," wrote Jeff Singer of the Cato Institute in an op-ed for the *Detroit News*. "As a result, many experienced foreign-trained doctors take positions in ancillary medical fields such as nursing, lab technicians, and radiology technicians instead of starting all over again. Some even work as waiters or taxi drivers."

Doctor Shortage

The nation's medical licensing laws for qualified foreign doctors are now under scrutiny because a serious doctor shortage is impending.

A June study published by the Association of American Medical Colleges says the United States is on track for an estimated shortage of 54,100 to 139,000 primary and specialty care physicians by 2033. Already, 80 million Americans live in an area with a designated health-professional shortage.

Congress has great influence over the number of practicing physicians because it funds all medical residencies in the country under Medicare. Lawmakers have the authority to increase the number of slots, but in its last opportunity—the COVID-19 relief package passed in December—Congress approved only 1,000 additional residencies over the next five years (see related article, page 3).

Some states are temporarily lifting occupational licensing laws barring doctors and other medical professionals from practicing medicine across state borders without paying fees and passing examinations.

Singer says the states should lift all restrictions and the change should be codified and made permanent.

"This pandemic has taught us that state occupational licensing laws, particularly as pertains to medical licensing, have been particularly restrictive, as governors realized when they relaxed them," Singer told *Health Care News*. "By suspending a lot of these regulatory obstructions, they've tacitly admitted that these regulations only serve to protect special interests. We should learn from this and not go back to the status quo."

"This pandemic has taught us that state occupational licensing laws, particularly as pertains to medical licensing, have been particularly restrictive, as governors realized when they relaxed them. By suspending a lot of these regulatory obstructions, they've tacitly admitted that these regulations only serve to protect special interests. We should learn from this and not go back to the status quo."

JEFF SINGER
CATO INSTITUTE

Putting Patients First

One concern about state legislatures possibly amending medical licensing laws is that foreign doctors could take jobs away from those in the United States, Pipes says. Physicians devote years of their lives and spend tens of thousands of dollars on clinical training.

"The United States needs many more doctors than its medical schools are producing," Pipes said.

Singer says restricting trained, quality medical professionals hurts the medical industry and the medical consumer alike because it insulates the industry from competition, which can improve the quality and cost of care.

"I think we should be less concerned with what hurts American doctors and more about what hurts American patients," Singer said. "American patients are helped by quality medical care and doctors, not just in all 50 states but in other countries."

MadelinePeltzer(**mpeltzer@hillsdale.edu**) *writes from Hillsdale, Michigan.*

Father of Obamacare Says Private Health Care Is Better

By Bonner Cohen

Private maternity and prenatal care meet much higher standards than government-run childbirth care, a study published recently by a center-leaning policy organization states.

The study, published in December by the National Bureau of Economic Research (NBER), compared childbirth care at government-run military hospitals with that provided by off-base private facilities. Researchers concluded, "the quality of care appears to be significantly higher for mothers delivering and receiving prenatal care off-base."

Jonathan Gruber, one of the authors of the study titled "Public and Private Options in Practice: The Military Health System," helped write the Affordable Care Act (ACA), popularly known as Obamacare, and was the architect of "Romneycare" in Massachusetts.

Noting health care in many countries is provided by a mixed public-private system, the authors sought to compare such systems in the United States and found the best context is the Military Health System (MHS). The MHS is a $50.6 billion-a-year program that provides care to active-duty military, their dependents, and military retirees, covering more than million individuals.

MHS Health Care Laboratory

"Crucially, MHS beneficiaries have access to government-owned-and-run military facilities on military bases, as well as private providers that are contracted to the military through an insurance company," the study notes. "Care is split roughly equally between the two sources; 49 percent of the outpatient encounters and more than 67 percent of hospitalizations for MHS beneficiaries take place with private providers."

As the largest broadly mixed health care delivery system in the United States, the MHS provided researchers with a large sample of birth data through which to study treatments and outcomes. Researchers gathered data from the 42 government-run military treatment facilities in the United States and from nearby private providers to the military via contracts with insurance companies.

Another feature unique to the MHS gave the researchers an additional basis of comparison: moves by recipients of care.

"Moves across military bases are dictated by the needs of the military and are not determined by the choices of individuals which might be endogenous to their tastes for medical care," the study points out. "Combining beneficial moves with another key feature of the military context—i.e., variation across bases in the availability of base hospitals—provides us with exogenous variation in access to a public system of care."

The study focused on childbirth, a category providing a large sample of individuals receiving care both on- and off-base for a major medical intervention. That allowed researchers to hold patient characteristics constant in comparing deliveries from different sources, as well as to take advantage of a detailed and consistent set of quality measures facilitated by the childbirth setting. The sample was large, covering 776,074 births to 590,353 dependents of active-duty military, with 43.63 percent of the children being delivered at military bases.

Fewer Complications Off-Base

The study found striking differences between births on base and those using private care.

"We find that mothers delivering off-base use more resources than those delivering on-base; total resource utilization appears to be about one percent higher for those using the private- rather than the public-care system, primarily driven by higher Cesarean section rates off-base," the authors write.

"At the same time, we find that the quality of care appears to be significantly higher for mothers delivering and receiving parental care off-base," the study states. "We find that mothers and babies receiving off-base care have fewer complications and incidents of maternal or neonatal trauma. Our results suggest that, at current levels, shifting childbirth from on-base to off-base is likely to be cost-effective."

NBER's findings showing the private sector clearly outperforming the public sector in the delivery of health care are something the Biden administration should consider, says John Goodman, president of The Goodman Institute for Public Policy and co-publisher of *Health Care News*.

"In the private sector, competitors are allowed to succeed or fail," Goodman said. "In the public sector, people are generally insulated from competition and they tend to be paid about the same regardless of what they do."

Bonner R. Cohen, Ph.D., (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

Did the FDA Stand Between You and COVID-19 Vaccines for Months?

By Raymond March

In October, large portions of the United States experienced rapid increases in new COVID-19 cases. Many European countries experienced a similar surge in cases, even after facing devastating COVID-19 outbreaks earlier this year.

Fearing the arrival of a second wave, several states reenacted various lockdown measures to curb the spread of disease. Many European nations followed suit. But necessity is the mother of innovation, and pathbreaking medical innovation has arrived.

Vaccine Available in December

On November 9, Pfizer announced it had developed a more than 90 percent effective COVID-19 vaccine. A week later, Moderna released clinical trial findings indicating its COVID-19 vaccine was 95 percent effective. Stanley Plotkin, the inventor of the rubella vaccine, found Moderna's results to be "extremely encouraging" and said they "show that the platform really works … and considering the speed with which the platform was put into operation, it's an excellent result."

Federal regulators agreed. On December 11, the U.S. Food and Drug Administration's (FDA) advisory board granted emergency use authorization for Pfizer's COVID-19 vaccine. Centers for Disease Control and Prevention (CDC) Director Richard Redfield gave similar approval shortly after, making a COVID-19 vaccine available to distribute.

Barring any unforeseen setbacks, Pfizer expected to produce 15 to 20 million vaccines by the end of the year, including 2.9 million doses in the next week. Moderna's COVID-19 vaccine was also expected to receive approval, with the hopes of distributing another 20 million doses by the end of December.

Pfizer's and Moderna's swift development of an effective COVID-19 vaccine has generated widespread and well-deserved praise. An opinion piece in *The Wall Street Journal* argues the scientists who developed the vaccines deserve the Nobel Peace Prize for their discovery. An article in the *Irish Examiner* called the leaders of BioNTech, which partnered with Pfizer to develop the vaccine, "heroes of our time."

Eleven Months to Approval

Even more remarkable, according to an article published on December 7 in *New York* magazine's Intelligencer, is that Moderna's vaccine was developed on January 13, only two days after the vaccine's genomic sequence was made public. This was even before COVID-19 reached the United States.

Until the FDA approved the vaccine, it was not legally available to anyone not participating in clinical trials. This means, as the article's title indicates, "we had the vaccine the whole time."

A nearly eleven-month gap between the vaccine's discovery and FDA approval is frustrating. Unfortunately, the FDA's sluggishness in approving lifesaving medication is nothing new, even during a public health crisis.

In the years 2014 through 2016, the Ebola virus caused nearly 11,000 deaths across western Africa. Scientists across the globe worked together to develop a vaccine in less than a year. The Ebola vaccine, however, did not receive FDA approval until 2019, four years after it was created.

Bureaucratic Bottleneck

Would medical scientists be able to develop and distribute a safe and effective vaccine quickly without the FDA's oversight? Evidence from previous influenza pandemics suggests they can. In 1957 and 1958, the 1958 influenza (often referred to as the Asian Flu) spread through the United States, infecting 20 million people and causing 116,000 deaths. At this time, the FDA held significantly less regulatory authority and did not regulate vaccines.

As with Moderna's COVID-19 vaccine, medical scientists developed a vaccine for the 1958 influenza before the virus reached the United States. Without the FDA prolonging approval, public health agencies and private vaccine developers were able to distribute 60 million doses of the vaccine during the first two months of the pandemic.

Consequently, hospitals were not overwhelmed and there was "no serious disruption of community life" during the 1957-1958 pandemic. As an article published at the time in the *Journal of the American Medical Association* noted, quick development, approval, and distribution of the vaccine "made it possible for a nation to organize in advance of an oncoming epidemic for the first time in history."

The frustrating delay between the time when a COVID-19 vaccine was discovered and the day the FDA gave its approval should not overshadow the Pfizer and Moderna scientists' remarkable achievement. Their pioneering discovery is truly phenomenal. However, acknowledging the harmfulness of the FDA's delay in authorizing a COVID-19 vaccine can help implement better policy during future public health crises.

COVID-19 is deadly. But regulatory barriers can be, too.

Raymond March (**think@heartland.org**) *is a research fellow at the Independent Institute and an assistant professor of economics at North Dakota State University.* *This article was published on December 15 in the FDAReview.org blog of the Independent Institute. Reprinted with permission.*

COMMENTARY

Lockdowns Spread Viruses Instead of Stopping Them

By William M. Briggs

Lockdowns kill. Suppose a bug is 100 percent transmissible. Everybody in contact with somebody infected therefore gets it and passes it on with certainty to the next person they meet.

A lockdown will spread this bug faster than allowing people to remain at liberty. Lockdowns are not quarantines in the old-fashioned sense of that term, where infected people were isolated—kept separate in every way from the noninfected. If you think *lockdown* and hear *quarantine,* your ears are busted. Quarantines can make sense; lockdowns never do.

A lockdown will spread this bug faster than allowing people to remain at liberty. Lockdowns are not quarantines in the old-fashioned sense of that term, where infected people were isolated—kept separate in every way from the noninfected. If you think *lockdown* and hear *quarantine*, your ears are busted. Quarantines can make sense; lockdowns never do.

Advantage: Big Business

Lockdowns are merely forced gatherings. People in lockdown are allowed to venture forth from their dwellings to do "essential" activities, such as spending money at oligarch-run stores. These stores are collection points, where people are concentrated. Some are allowed to go to jobs, such as supporting oligarch-run stores.

The decision over which stores are allowed to remain open and which are forced to close is arbitrary. This does not include standalone restaurants, for instance, but you can eat in oligarch-run company cafeterias, as at Costco. Google employees can eat in their own cafeterias or break rooms, too. Restaurants can still come to you, via delivery. These are concentration points. You can go to a grocery store, but some aisles, those containing forbidden items, might be closed off, thus forcing people into fewer spaces.

Lockdowns are not quarantines. Lockdowns concentrate people into fewer areas. Lockdowns cause only pain.

No Effect on Transmission

Lockdowns allow people to go outside to mingle and collect germs, then they force them back inside to spread those germs with a vengeance. It's clear that our 100 percent transmissible bug will spread much faster when people are forced to spend more time indoors with each other. Once one person gets it, he will spread it to those at his home immediately. If people were at liberty, and therefore more separated, the bug would still spread to everybody, but more slowly (the speed here is relative).

Now suppose the bug has only a one in a 1,000 chance of spreading per contact. That is low. Lockdowns will still spread it more quickly than liberty, and for the same reason. Lockdowns force people together. The venues where people are allowed to venture are restricted, which concentrates contact, and the lockdowns force people to spend more time inside their homes where it's obvious contact time increases. Lockdowns concentrate contact spaces and times.

The transmission rate, then, has little to do with the efficacy of lockdowns. There is no efficacy of lockdowns in preventing transmission, only in controlling where the transmissions will take place.

Alternative: Liberty Plus Quarantines

The opposite of the lockdown is quarantine-liberty. The ill are quarantined, kept entirely separate from the healthy until they are dead or otherwise no longer communicable. Because of cheating, transmission is still possible, but it's far less likely. Liberty of the healthy allows people to live their normal lives, which slows transmission. And it does not concentrate power into the hands of the government or oligarchy.

It was obvious before 2020 that lockdowns—with then only weather forcing people to gather inside for long periods—not only did not stop the transmission of bugs but helped spread them. The all-cause death numbers peaking every single winter without exception (this year, too) proved that. It was in no way controversial. It was so well-known that forced contact spread bugs that mentioning it was like saying the sun rose in the east.

The Expert Circular Jerk

Then came 2020 and the "expert" idea that lockdowns would do the opposite of what everybody had always known they would do. Suddenly, instead of spreading bugs, as they always did before, they would stop or at least slow the spread. Experts said so. Why?

Models. Specifically, the two-step Model Circular Jerk.

It works like this. A modeler says, "X is true." He builds a model that assumes X is true. He runs the model, the output of which consists of "X is true" and its variants. He then announces, "X is true, confirmed by my sophisticated computer model."

In our case, we have Neil Ferguson, a British epidemiologist, claiming early this year that some new variant of the coronavirus has higher transmissibility—which is just an assumption. He says to himself, "Lockdowns slow and stop the spread of bugs." He builds a model that assumes lockdowns slow and stop the spread of bugs. He runs the model, which consists of "This lockdown will slow and stop the spread of this new bug variant." And he announces he has confirmed the efficacy of lockdowns via his sophisticated model.

And people believe him. This happens everywhere, not just with the coronavirus. All that being said, the only thing that makes sense in modern lockdowns is limiting mass gatherings where mass intimacy is expected, such as at riots. Even then, the higher the transmissibility, the less of an effect these bans will have.

William M. Briggs, Ph.D., (**matt@wmbriggs.com**) *is a statistician and is author of* The Price of Panic: How the Tyranny of Experts Turned a Pandemic into a Catastrophe. *This article was originally published on December 29 at wmbriggs.com. Reprinted with permission.*

Database Shows How Feds Are Robbing States of Health Control Authority

By Bonner Cohen

A new database aims to show policymakers and the public how federal regulations are robbing states of the ability to manage health care.

The database, called State HealthReg Data and created by scholars Kofi Ampaabeng and Elise Amez-Droz, a program manager at the Mercatus Center at George Mason University, quantifies the volume and characteristics of federal health care regulatory restrictions so states can "examine the impact of regulations on the practice, delivery, and outcomes of medical care."

The database looks at a wide variety of measures from professional licensure and provision of care at institutions to health care financing and drug manufacturing and distribution.

"Providing healthcare in the United States is complex, the result of various levels of regulations—such as the rendering of services by medical professionals, the education of medical professionals, the provision of care by institutions, the manufacturing and dispensing of drugs, the financing of healthcare services provided to patients, and many others," Amez-Droz and Ampaabeng state in the introduction to the database.

Measuring Barriers to Innovation

Regulations often bypass their original intent, the authors state. Instead of improving quality, access and affordability, regulations cause the market to stagnate over time.

"The intricacy of these regulations favors industry incumbents that have the expertise and resources to maintain their position," Amez-Droz and Ampaabeng write. "It also constitutes a barrier to new entrants, shielding industry members from competition and innovation, which patients depend upon to ensure better care at a lower cost, year after year.

The nation's health care system is anything but a free market, and its problems are mainly caused by government, Amez-Droz says.

"Our complex health care system is the result of decades of federal and state regulations that purport to improve access and quality and control costs, and yet we hardly take stock of the impact the volume of health care regulations that have been enacted has on the health system and health outcomes," Amez-Droz told *Health Care News*.

"Measuring and identifying all health care regulations is the first step towards objectively measuring the impact of the myriad of regulations on health care," Amez-Droz said. "In addition, with State Health RegData, researchers, policymakers, and the public alike can identify and compare the regulatory regime across states."

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>
> **ELISE AMEZ-DROZ**
> **PROGRAM MANAGER**
> **MERCATUS CENTER**

The database can show health care in a new light, Amez-Droz says.

"With this information, lawmakers in Oklahoma, for example, can ask, 'Why do we have certificate of need laws, but Texas doesn't?'" Amez-Droz said.

Bonner R. Cohen, Ph.D., **(bcohen@nationalcenter.org)** *is a senior fellow at the National Center for Public Policy Research.*

INTERNET INFO

Kofi Ampaabeng and Elise Amez-Droz, "State Health RegDat 1.0: A Quantification of State Healthcare Regulations," Mercatus Center, George Mason University, October 14, 2020: **https://www.mercatus.org/publications/healthcare/state-health-regdata-10-quantification-state-healthcare-regulations**

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